MEDICAL PLURALISM IN OPERATION IN A SQUATTER SETTLEMENT (GECEKONDU) IN ISTANBUL: TRADITION, EXCHANGE AND AGENCY

By

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By

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Chair: Professor Brian M. du Toit
Major Department: Anthropology

The purpose of this descriptive dissertation is to explore the concept of medical pluralism, as it relates to a sample of Turkish migrants residing in one of the squatter settlements in Istanbul. To garner this data 119 short interview schedules were conducted primarily among women in the Umraniye gecekondu of Istanbul; additionally, four interviews were conducted with medical professionals, four informal interviews were taken with various other medical professionals (nurses, hospital technical staff), 29 short interviews were conducted among pharmacists in the Umraniye area (a region of Istanbul), two open ended interviews were taken with Umraniye community Imams, two interviews were conducted with herbalists (in addition to informal reconnaissance at various herbal shops in Istanbul), and four months of observation at a local public health clinic informed this study. My main goal in speaking with this diverse group of people

was to find representation and perspective among the various health care sectors available to my core group, the women in the *gecekondu*. Further to this goal, I examine some of the theoretical aspects of decision making in a given health care system–which is a creative process, involving personal inclination, economic factors, social status, gender, religious affinity, and governmental resources.

Results of this study indicate that among the *gecekondu* women there is a hyperawareness about "correct" behavior with regard to illness and disease. Additionally, while there was a general consensus among all sectors that 'doctor knows best," the reality of the situation is that resources are not adequate to meet the needs of many of the lower SES inhabitants of the *gecekondu*, and stresses may be seen on both sides of the continuum: the doctors are underpaid and understaffed, the state hospital facilities are not on a par, technologically, with the private hospitals, and because of inadequate care, there is some confusion on the parts of the population which the state hospitals serve about the quality and attention (lack thereof) received: a crisis of confidence seems apparent in the attitudes they have fostered toward this health care system.

INTRODUCTION

My decision to look at the health care system in Turkey was the result of several factors pulling me there. In 1995 I participated in an archaeological excavation in Iznik, in western Turkey, and found that the place was not only beautiful, but the people complex and culturally rich. It was hard to focus on the "dead things" beneath the surface when the living Turkish spirit was so strong and compelling. I made a decision at that time to return to Turkey and to learn more about its history and culture.

In 1998 I ventured back to Turkey to study the language. During this time I fell in love with Istanbul, and began to notice how diverse and socially stratified the city was. The dichotomy between economic classes is striking, and yet there is a persistence among the economically disadvantaged to overcome the obstacle of poverty and make the most of resources available to them–in short, to overcome unfortunate circumstances and prescribed social station, and to strive for something "better." Of course among the enterprising population I studied, there was also a realism about the order of things, and even a fatalism about how much one could accomplish in a lifetime; but the fact is, those who took the chance to migrate to Istanbul from their familiar homes in the central plateaus and Black Sea towns took agency in their lives for the sake of upward mobility. In no place was this spirit more apparent to me than the *gecekondu* the squatter settlements in peri-urban areas of Istanbul. My interest in medical anthropology further

fueled my desire to find out more about the people living in the *gecekondu*, and how they deal with health stresses.

Entry and First Impressions

My first week in Istanbul (June 2001) my photography assistant Kaan and I went around the *gecekondu* taking cover shots of the health clinic I would study, and also of medical posters and other items of interest. It was very hot and I was wilting under my hat--but I was determined to set about the task of learning my catchment area. Before embarking upon this venture I had not thought about the geographical and logistical difficulties of getting around my study area. Ümraniye is located on the Asian side of Istanbul, and there are some 900,000 people in this area. The health clinic is at the southwestern most point of Ümraniye, and the *gecekondu* settlement that interests me is at the northeastern most point. So the two points are not really within walking distance of one another, at least not by any definition or gauge I use. My assistant, being a denizen of the European side, had no idea how to navigate this region, but he was pretty good about asking for directions. We finally boarded one of the hideous dolmus buses (a shared taxi for as many patrons as will fit onto the mini-bus) and after some time arrived at what looked like a ghost town. There are around nine million people in Istanbul, but here at the "edge" there were no cars, no people, nothing. The wind blew hard making little dust devils in the street and I kept an eye out for wayward tumbleweed. It was kind of eerie. Finally we flagged down a man who looked for all the world like he was hurrying away from some unseen terror. He looked at us and laughed heartily,

probably wondering how we had managed to stray so far from the Grand Bazaar and other tourist attractions. I felt like I had stepped into a Fellini or Dario Argento film. Cats were fighting in the distance. Two small children who looked old beyond their years watched intently from across the street. Kaan described where we wanted to go, and the stranger whistled, took a deep breath, and then explained how we could find the area. Apparently we had missed our mark by a few miles. Then, as if on cue, a dolmus came whizzing around the corner and screeched to a halt next to us We hopped aboard and rode blindly toward our destination. . . or not. I asked Kaan if this was the right dolmus. He didn't know. Nobody knew. But I felt calm. Something about the territory became increasingly familiar as we rode on . I asked the dolmus driver to stop (Kaan looked mildly alarmed). We got off and walked a few blocks, and then suddenly we were there. Kaan looked at me, stunned. He was not quite convinced that this was it. Yes, I said. There's the grazing field, there's the *gecekondu*, and up on the hill there's the prison (landmarks that had been described to me). I located a reference street on my map. This was it. We proceeded to walk around the area, with me "helloing" everyone I passed (much to Kaan's embarrassment). We took photos of some of the makeshift buildings and homes, some of the children, and I tried to take one of a beautiful older woman from southeast Turkey we met. She wore an immaculate white scarf and her hands were stained with henna. She kept that scarf pulled across her face, but her eyes were very bright and she had a wonderful "game" sense of humor. She was too shy to have her photo taken (especially in front of Kaan), but she invited me to come back the following week.

The women we met were very hospitable, and sociable. They work very hard and they have virtually nothing, yet they temper these hardships with humor and a joyful spirit. Which is not to say that they're blithely unaware--but they manage.

Summary of Chapters

In this dissertation, Chapter 2 deals with medical anthropology as a unique subdiscipline within the broader field of anthropology. This area of research is truly multi-disciplinary, borrowing liberally from the medical sciences, economic theory, and philosophy, while maintaining a grounding in traditional anthropological thought (maintaining emic/etic perspective while conceptualizing the research in a holistic way). Of additional importance in this field is exposing disease prevalence and the social inequities, which contribute to the poor health status among many groups in the developing world.

Chapter 3 introduces the research design that guided the fieldwork that informed the present paper. Included in this chapter are definitions of qualitative and quantitative research tools used in anthropology, and which of these were most helpful for me in the field. The sample is defined and justified, and the various goals of the project are outlined.

Chapter 4 focuses on the geography and demography of the study area (Ümraniye *gecekondu*), as well as the political economy governing those individuals in the study sample, and the social, economic and historic aspects of modern Istanbul, paying special heed to the recent economic crisis (February 2001) that resulted in gross depreciation of

the Turkish Lira. Also discussed in this chapter is the issue of migration–theories on the broader end of the spectrum, and ideographically with regard to the present sample.

In chapter 5, I introduce the various health care sectors in Turkey. From the biomedical sector, hospitals, doctors and associated standards and practices are discussed, and from the folk medical sector, the personnel associated with these practices are introduced and defined in the context of Turkish culture.

Chapter 6 shows the results of 119 interviews with women from the Ümraniye settlement (*gecekondu*). Attitudes about health and nutrition are discussed, as well as general economic status of the study participants, demographic information in general, and issues such as consumerism among those from the lower income levels. Health status indicators such as nutritional intake, physical well-being and prevalence/incidence of illness all provide a snapshot of overall health among this group.

Ethnopharmacology is the subject of Chapter 7. The subfield is introduced, defined and explored via a survey of the literature. Additionally, information about attitudes and treatment is explored, and derived from first hand interviews with Istanbul herbalists. Also included in this chapter are results of the short interview schedules relating to folk knowledge about herbal remedy.

Chapter 8 is a look at Islam and Turkey, and also the lexical/linguistic aspect of illness–i.e., the "language of distress" with its associated cognitive framework. Common superstitions are explored, and statements regarding the supernatural among the Ümraniye sample are given. An analysis of domains of thought is included in this chapter.

Chapter 9 is an exploration of the biomedical model in Turkey. The medical hierarchy in this health care system is outlined, and data obtained from interaction at the local health care clinic in Ümraniye are shown. Also, the results of a pharmacy interview schedule and interviews with medical staff serve to illustrate how these sectors work in concert, and with the health care system in Turkey.

Chapter 10 provides a summary and discussion of the findings of this study. Additionally, some issues of importance to medical anthropology in Turkey are explored: namely, complex human emergencies, doctor complicity in state sponsored torture of political dissidents, the changing state of gender roles from a rural setting to an urban setting, and a comparative analysis of medical pluralism in Turkey–more specifically as compared with the United States.

CHAPTER 1
CHOICES

Introduction

Turkey occupies the large peninsula of Asia Minor (Anatolia) and a small portion in Eastern Europe known as Thrace (Figure 1). Istanbul (formerly Byzantium, and Constantinople)

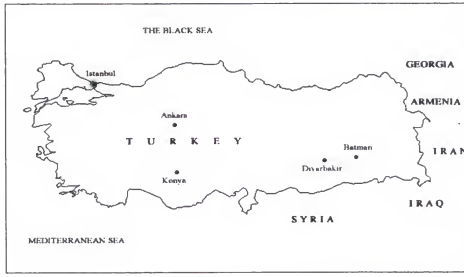

Figure 1 Map of Turkey

is an ancient and sprawling city famous for its unique location on a narrow stretch of land that bridges "east" and "west": the city straddles the Bosphorus (a beautiful strait that runs between the Black Sea to the north, and the Sea of Marmara to the South--a topographical peculiarity created by melt-waters during the last Ice Age), in such a way that half of the city is located on the continent of Europe (more specifically Eastern Thrace) and the other half on Asia Minor, a large (and I hasten to add tectonically active)

plateau which extends eastward toward the Caucasus, Iran, Iraq, and to the south Syria. Until the mid-1950's, cereal production and animal husbandry were the staple economies in the region, along with the production and export of items such as pistachio, fig, tea, tobacco and olive oil. Agriculture was the basis for the Turkish economy, with approximately 3/4 of the population actively engaged in this pursuit. However, with a shift to a market economy the labor market and social landscape have changed drastically. According to *The Turkish Daily News* (June 3, 2001), The Confederation of Turkish Labor Unions (Türk-IS) reports, "10 million people living in Turkey exist below the bread line. On the outskirts of the big cities, there are growing rings of poverty. The problems there are gradually multiplying and no measures are being taken. Analysts fear that the income gap will be the biggest problem facing Turkey in the coming years."

Turkey is both climatically and topographically diverse, and depending on where in the region one looks, there are drastic changes in the landscape. This diversity provides a large range of possibilities for food and cash crops. There are seven geographical zones, and five main agricultural zones, namely (see discussion in May 1961):

1. The Black Sea Region: a coastal strip where hazel nuts and to a lesser degree citrus fruits are grown. Also, maize is the most important item grown in the region, and tobacco and tea are also grown here.

2. The North West Coast: an area where the Black sea eventually meets the Sea of Marmara via the Bosphorus: here wheat, beets, maize, sugar, sunflower, olives and livestock, as well as grapes, fruits and vegetables are cultivated.

3. The Aegean Coast: here olives, figs, grapes, grow without irrigation, and cotton, maize and vegetables are grown with irrigation.

4. The Subtropical Climate of Antalya: bananas and citrus are the most important crops in this region.

5. The Central Plateau: livestock grazing pasture, as well as grain grows in this region. In general, both animal husbandry and agriculture contribute to the food supply.

With regard to traditional family level food supply and economy, May [1961: 582] reported:

> A typical farm in Turkey on the Anatolian plateau would comprise approximately 8-10 hectares. The owner might have had a couple of years in school, his wife would have–typically–had none, and they would work the farm together with their children. They might have a team of horses doing most of the work of plowing, and they might get help for a short time from a hired tractor. In addition to the land, they would own 20 sheep and two cows that would graze the village common or the fields that are left to fallow. The grass never gets high enough for the animals to be satisfactorily fed, because these pastures are heavily overgrazed. In addition, the family might own 12-15 chickens, supplying 550 eggs and 35 chicks. This family would also have a small income from surplus.

Despite a broad range of food choices, it is the food preparation and cooking habits that play the most important role in diet selection. Perhaps because fuel is so expensive, it is a common practice to cook provisions for the entire day at one time. As a result, cooked vegetables in a cold salad and other cold meals are often served. A typical breakfast will consist of tea, bread, olives and "white" (feta) cheese. Lunch is usually leftovers from the previous night's dinner. Dinner is the most important meal of the day and may consist of vegetable, occasionally meat, pilaf, a sweet, and bread, which is a staple at every meal. Also, tomatoes are the most ubiquitous vegetable in the Turkish diet–and a mainstay of many dishes. In general, production and consumption of meat are very low, and in most families only eaten once or twice a week. Of trends in meat consumption, Dedeoglu (1990:390) states: "Annual meat consumption per person had fallen from 35 to 27 kg., fresh vegetables from 150 to 116 kg. and fresh fruit from 100 to 67 kg. The

situation was worse in small towns and villages where 11 kg. of meat consumed per person in 1974 had fallen to 4.5 kg. in 1982." The most common meats consumed are lamb, beef and goat, and chicken (to some extent donkey meat is also used). However, it should also be noted that there are regional variations. In the northeast meat and dairy products are more plentiful, fish is available in the coastal regions, and fruits and vegetables are abundant in the Mediterranean and coastal belt.

Another consideration in the diet is the influence of neighboring countries. As May (599) pointed out:

> The following diet regions may be delineated. In the Anatolian plateau wheat is the main food, in combination with cheese and yogurt, or other dairy products. Consumption of fats and oils probably is at its lowest in this area. Diet in the Black Sea region is characterized by the use of corn and corn bread, which are staples. However the government is encouraging a shift to the use of wheat and other cereals, so consumption of wheat is increasing. Fruits and vegetables are available in large quantities in this region. Wheat bread also is the staple of diet in European Turkey and in the Aegean region, but there is abundant consumption of fresh vegetables and fish.

It is also noted that fresh milk is not usually used as a beverage–it is usually in yogurt form or as a watered down and salted drink called *ayran*. Delaney (1991) also looked at gender relations with regard to food production and consumption:

> During the day the spheres of activity of men and women are separate. In many villages...this separation is continued even at meals: men and boys eat first in the sitting room, and only after they have finished do the women and girls eat the leftovers in the kitchen." But Delaney notes in the town of Gokler, "all members of the household eat together, and this has to some extent mitigated the strict reserve normally exhibited between husband and wife. (1991:176)

Attitudes about rearing children contribute to our understanding of a culture's nutritional profile. In Turkey female babies are ideally nursed for up to 18 months, while male

babies may be nursed for two years. This extra nursing is said to give the male babies the "strength they will need to endure [compulsory] military service" (Ibid:72).

Kocturk (1988), in studying a sample of low SES and high SES breast-feeding mothers, found that while above 90 percent of the mothers breast-fed infants in the first month, numbers dropped considerably by the third month. Kocturk's results show a positive correlation between lower SES (in Istanbul) and length of breast-feeding. Aksit and Aksit (1989:574) echoing Delaney, found "a significant relationship between sex and nutritional status of infants and children in favor of males." This study also showed that the longer babies were breast-fed, the poorer their resulting nutritional status. Therefore, in addition to urban/rural and gender considerations, one must take socio-economic status into account when analyzing nutritional features of a population.

Other cultural variables may include Ramadan, a religious fasting period, menstruation, which is thought of as a contaminating period, and also pregnancy the first 40 days of gestation and the 40 days after birth–times which are critical and require special attention to diet and behavior. This latter point is discussed further in Chapter 8.

In addition to sustenance support resources, the Anatolian landscape–with its marked environmental and ecological diversity–is host to many indigenous plants, which hold a place in folk pharmacology (Sezik et al. 1991; Honda et al. 1996; Sokmen 1999; Yesilada et al 1999).

According to these data nutritional resources should be sufficient for the population to receive a healthy diet; however, some cultural influences dictate dietary

intake. In consequence, various deficiencies continue to be reported–both among children and adults in the region.

While there were many potential sites of enquiry, as it were, to choose from, I felt that studying a small town or village in isolation would limit the scope of this study, for which I wanted to focus on the concept of medical pluralism. Therefore, it seemed logical to look at *the* hub for economic change and migration in Turkey, Istanbul. Istanbul is host to some 192 state hospitals and private facilities (with a total bed count of 33,821), and also contains a variety of other health care influences, from the learned home remedies of some of the inhabitants (natives, foreigners, rural and urban), to the latest medical treatments available over the counter in pharmacies, to the more trendy health food and alternative health care facilities available.

The Turkish approach to illness and disease involves a complex system of networks and can incorporate elements of both traditional and clinical medicine. In her study of traditional and clinical medicine along the Black Sea coast, Onder (1998) wrote of a local distinction between "traditional" and "clinical" medicine. Both camps are characterized by the way in which knowledge is transmitted. Traditional medicine is learned in the local setting from peers and mentors, and also by observation of those who have healing talents, while clinical medicine must be undertaken formally at a learning institution. Setting and the tools of the trade are the fundamental distinctions. Turkey itself is a land of contrasts: a culturally Islamic society under secular government; with technologically advanced city centers surrounded by rural villages; a region in which traditional kinship patterns persist alongside "western style" family structures. There are

institutions of Western biomedicine in the hospital (*hastane*; literally "sick house"), which stand juxtaposed to the *hoca* (religious healer). This contrast (that is, between biomedicine and folk remedy) becomes an evident system of conflict when Turkish migrants from rural areas are faced with the different choices in health care available in cosmopolitan areas.

In this discussion I evaluate the health care system in Turkey by exploring a number of issues of medical importance, ranging from the administrative aspect of governmental control and resources, to the individual strategies used by women in my core sample. Also explored is the conceptual framework for this study: associated theories within the field of medical anthropology are discussed and critiqued.

History and Politics in Perspective

One of the most striking features in Turkey is the contrast between political and cultural ideologies. This contrast is a key element in the examination of social and political inequities in the region. Therefore a brief history of the nation is necessary to place the facts in the appropriate context. The republic of Turkey is a relatively new nation, and one that is steeped in a long history–including both prosperity under the Ottoman Empire, and ultimately decay under that same empire. One of the most dramatic shifts in political and social structure was seen in Turkey in 1923, as Mustafa Kemal Atatürk established the first Turkish Republic (Karpat 1976; Dodd 1969). From 1922 to 1924 the sultanate, the caliphate, the Office of Seyh'ül-Islam and the Sharia courts were abolished (Kazancigil 1991; Cizre-Sakallioglu 1994). Atatürk was inspired

by the theoretician of Turkish nationalism, Ziya Gokalp, who promoted a move away from Islam and toward Western-styled progress (Brown 1988). Subsequently, the secular movement known as Kemalism gained momentum and a tenuous hold over the nation, as Muslims for whom Islam was completely ingrained in culture, state, family, and in every facet of life, submitted to the new ideal. The promise of a popular democracy by the people and for the people—echoing the Western tenets of freedom—further promised to restore respectability to the Turks. Secularism was vehemently protected against the infiltration of religion into state. With such neighbors as Iran and Syria, and an innate distrust of the European powers that had divided most of the Middle East, this resolve was reinforced by a powerful military, which would prove to be the guardian of Atatürk's ideals if the government went astray.

One of the most effective means of mobilizing such a large and heterogeneous group of people and leading them into an essentially alien political system was by rapid and organized control over the government by Atatürk and his followers. Religious laws were summarily abolished as a secular jurisprudence based on the Swiss, Italian and German systems was instituted. The Republic became a kind of dedicated democracy as reforms required schooling for young children, banishment of the veil and polygyny, changing of the written language literally overnight from the Arabic script to the Roman alphabet, and encouragement of Turkish nationalism that sometimes approached totalitarian proportions. Atatürk described the Turkish revolution as a mission of patriotism and humanism.

So far the motives were good and morale was high in the face of a new frontier of popular political autonomy. Unfortunately, it was not long before the realities of economic recession and divided loyalties among Atatürk's critics were exacerbated by a seeming rebuff on the part of the European community in the West and on Turkey's neighbors to the east. Anatolia has often been described as the bridge between the east and the west; however as Turkey struggled to rebuild its nationhood, it was rejected on all fronts by conflicting ideologies.

In the meantime, Atatürk's single ruling Republican People's Party [CHP] evolved into a two party system as his successor Inonu reacted to pressures from Turkey's Western allies to move toward a more pluralistic political format (Leder 1979; Brown 1988; Heper & Evin 1994). The Democratic Party was created and in 1950 won the elections overwhelmingly over the CHP. In reality, the DP seemed to have had close ties with Islam, and attempts were made to secure the votes of Muslim villagers who constituted 75% of the electorship (Heper & Evin 1994). As this group courted the peasantry, the tenets of secularism became relaxed and resulted in a rise in popular Islam. However, in 1960 the guardian military initiated a coup d'etat, citing corruption among Democratic Party personnel. In 1965 the Justice Party (JP), led by Demirel, became a champion of Islam. By this time the Republican People's Party realized that its strict adherence to secular policy prevented it from gaining the village and peasant vote, and eventually it went as far as attempting a coalition with the extreme Islamic National Salvation Party, which was a descendent of the National Order Party and headed by the outspoken Necmettin Erbakan. During the 70's the National Salvation Party gained up to

11.8% of the vote at times, and made the military very nervous (Heper and Evin 1994). In 1980 another military coup was initiated; the restoration of a more Centralist party, the ANAP or motherland party, put an end to the fervor seen in the seventies, and restored a more Kemalist outlook. Today there are six major, nationally recognized political parties, which are the Republican People's Party [CHP], the Justice Party [JP], the Motherland Party [ANAP], the True Path Party [DYP], the Social Democratic Populist Party [SHP]; until recently the Refah or Welfare Party [RP] was an aggressive contender and champion of the Islamic cause (this group was banned but later regrouped). It is this last party which has recently caused the greatest stir in Turkey.

One of the most outspoken representatives of the Islamist movement in Turkey in recent times was Necmettin Erbakan – whose name was synonymous with the Welfare Party. Erbakan, now in his 70's, has been instrumental in the evolution of the Islamic faction all along. In 1969 he acted as an independent in a conservative Konya province; it was in 1970 that he and a group of associates founded the Milli Nizam or National Order Party. This party sought a long-term strategy to find a practical solution to the problems seen in modern Turkey but the party's strong Islamic leanings and outspokenness led to its ban in 1971 by the Constitutional Court.

In 1972, the Milli Selamet or National Salvation Party (NSP) was founded and under Erbakan's leadership, by 1973, became the third largest party in Turkey (Metin and Evin 1994). One of the unique aspects of the NSP was that it contributed to the evolution of modern political Islam, and was instrumental in changing the strategy from a short-term goal of gaining electoral votes to one in which the importance of Islam in Turkish

politics was promoted (Cizre-Sakallioglu 1994). Additionally, the NSP helped to change the social climate for Islam by promoting and establishing Quran courses, publications in journals and, in general, broadening the scope of the Islamic movement (Cizre-Sakallioglu 1994). However, the 1980 military coup d'etat dissolved the organization. Erbakan and his colleagues were banned from political life until the September 1987 referendum.

Erbakan used the time to regroup, and with the referendum, in 1987, became the leader of the Refah Party (Welfare Party) which was founded in July 1983—a regrouping of the previous Islamic parties.

As the Right Wing slowly developed a legitimate place in Turkey's political system, the secularist parties, and in particular the conservative DYP or True Path Party backed by President Süleyman Demirel and Prime Minister Tansu Çiller, had become less and less popular among the rural peoples and the lower economic classes. Growing conflicts between Çiller and Demirel were seen, and whispers of corruption undermined the government's authority. However, while the secularist parties pandered to the elite European and American-educated of Turkey, the Refah party quietly stepped onto the scene, and began to influence the previously voiceless poorer classes–promising greater economic success and importantly assistance with a growing number of health issues.

Identity crisis

One of the major problems of the Kemalist outlook (at least from a western secular viewpoint) was that by denying social class, as was its goal, it invited the

peripheral peoples to participate in the political process. However, by so doing, it brought a tradition and religious bound group into a system whose goal was based on the negation of Islam (Cizre-Sakallioglu 1994). Necmettin Erbakan returned to politics to capitalize upon this constituency, but this time he shed his radical Islamic epithets in favor of moderate slogans that were less threatening to the wary military and government. As the True Path Party rallied to include Turkey in the European Union, Erbakan's Welfare Party sought local appeal. The party's nickname "Refah," meaning "comfort," opened women's shelters and soup kitchens; and told the rural peoples of eastern Anatolia, who were often without basic utilities such as running water and electricity, that not only were their cultural and religious beliefs acceptable, but that they could improve their position by installing a leader that cared about the people's needs, not Western cultural and material attainment.

The Refah party participated in the 1991 general elections and received 62 seats in parliament out of 550. In 1994 the party doubled its votes in the nation-wide local government elections, capturing 6 metropolitan cities including the capital Ankara, Istanbul, and 22 other cities. In other words, two out of three portions of Turkey had chosen the Refah Party.

In the 1995 General Elections, Refah had won 160 parliamentary seats out of 550—still short by about 115 votes. At the same time, Tansu Çiller's True Path Party (the DYP) was not able to reach the majority. In a move somewhat reminiscent of the Peoples Republican Party and National Salvation front, the two parties decided to form a coalition in order to conquer parliamentary seats. In a vote of confidence the coalition

won by 278 against 264 votes—a very close race which reflects the deep divisions within the government. Turkey's 54th government was headed by the Welfare Party's Chairman and Prime Minister Necmettin Erbakan, bringing 70 years of secular rule to an end at least for the time being.

Different political groups emerged when a single-ruling party deferred to political pluralism and each embodied an outcry against either socialist or Kemalist ideologies that sought to destroy the Islamic identity. In the case of Turkey, Erbakan attempted recently to dispel questions and fears that the staunch secularists voiced about the Refah Party. It was promised that domestic and foreign matters would move along the same lines as the DYP had initiated; that is, Turkey would continue to seek status in the European Union, to crush the deficit, to diminish unemployment, eradicate terrorism, and in general all of the governmental problems at issue in the past decade. Additionally, Erbakan reiterated that Refah did not intend to invoke Sharia and, in short, that the ideals of Atatürk would remain intact.

For a number of months these promises, along with Erbakan's charismatic leadership and Çiller's head for business, seemed a perfect marriage. But eventually this relationship began to deteriorate. Critics of Refah have begun to detect vacillation when it comes to secular promises, and proposed Islamic institutions, such as a lifting of the veil and fez ban has been interpreted as a sign that Erbakan , now with a strong hold in the government, may revert to his old Salvation Front radicalism. Though Çiller has been exonerated of the numerous corruption charges she has faced over the past few months, her authority has suffered and further strengthened Refah's position. Additionally, a near

crisis was seen in the suburb of Sincan just outside of Ankara in the late 90's, when the Iranian ambassador Bagheri advocated a move to Sharia in Turkey. The champions of Atatürk, the Turkish military, marched on Sincan and issued a sound warning that Islamic fundamentalism would not be tolerated. Subsequently a censure motion was made against Erbakan's regime, but secularists were not able to come up with enough votes to topple the Refah government. Now, as things continue to heat up, a strained relationship between the Welfare and Secular parties presents a troublesome dynamic that waits to be played out.

Given the tenets of individual freedom and economic success that democracy promises, the rise of political Islamic fundamentalism might seem puzzling. However, when a country reaches its critical mass of tolerance for poverty and widespread neglect of the underclasses, hope and solidarity must find a more culturally significant route. In January of 2002, this issue was still hotly debated. As of September 2002 Islamic movements are still cropping up, and while the motivation may be political for many of its supporters, for many others (such as residents of the *gecekondu*) the agenda means a greater expression of social and religious values at a basic level: that they may receive equal care and recognition without bias against their belief system.

Questions and Hypotheses

The driving questions behind the project discussed in this dissertation are as follows:

Hypothesis 1: When a sector of the population suffers from social or economic inequities in relation to society as a whole, health status will suffer as a result, and those individuals without the means to pay for advanced medical care will fall back on traditionally meaningful methods of remedy.

Hypothesis 2: When rural migrants are faced with health stresses in the new urban environment, social pressures from the urban matrix will cause a re-evaluation of traditional treatment of and attitudes toward illness, and force those individuals to adapt the encapsulating health care system.

To inform these hypotheses were a number of goals implicated in the following questions:

1. An evaluation of the health and nutritional status of a sample of migrants living in a squatter settlement *gecekondu* in Istanbul must be undertaken to determine the extent to which poverty and social station influence health care strategy.

2. The interrelationship among health care sectors (professional/biomedical and folk) must be examined to assess the extent to which services from each are used by the core sample from the *gecekondu.*

3. Some of the structural and procedural problems associated with health care management in Turkey must be explored.

4. An outline of some of the medical problems, which lower socio-economic groups face, must be presented.

5. Examination of the cultural matrix of the core sample must be undertaken.

6. Examination of the economic situation in Turkey and how poverty affects those at the lower income levels residing in the city must be explored.

There are several factors that lead to my assumption that medical pluralism would be the operational system of health care management in Turkey:

1. There is an influx of groups from rural Turkey into city centers such as Istanbul, each arriving with a core belief system that may or may not be at odds with the encapsulating governmental health care system.

2. There is a lack of economic security among rural migrants, which has been compounded by a national financial crisis, which saw the depreciation of the Turkish Lira (TL) from around 40,000TL to the US Dollar, to 1.4 million TL to the US Dollar. Therefore, financial resources would become even more limited and force individuals to apply a creative strategy for dealing with illness. However, I would like to note, as will be seen further in the discussion, that a paradox exists in the collective attitude of the focal *gecekondu* residents:

1. They have been thrown into an environment where the contrast between socio-economic strata is much more obvious than that of the rural area from which they came, and

2. Social networks and "village" values persist (along with a generally more conservative family structure and religious belief system), and this in turn creates a division between the native city population and the rural factions who migrate there.

Therefore, the purpose of the project was to identify the mechanisms for transfer of medical knowledge, with special consideration for epistemological and ethno-medical dimensions, which are informed by beliefs, social organization, religion, politics, and the relative isolation (socially, economically, geographically, etc.) of a particular community.

CHAPTER 2
THEORETICAL ASPECTS OF MEDICAL ANTHROPOLOGY

Introduction to Biomedicine and Traditional Health Care

A number of empirical generalizations exist with regard to disease and treatment of disease among groups cross-culturally. Because disease is a universal and inevitable fact of life, and because systems of knowledge are interpreted differently, all human groups develop methods and strategies and a health theory system that is meaningful in a given cultural context. Therefore, the beliefs inherent in a given cultural matrix reflect how the human body in all of its physical manifestations is perceived and dealt with.

Medical knowledge takes a number of forms. From clinical medicine in its biotechnical incarnation, to herbal medicine, spiritual therapeutics, and combination therapy, methods are sought to heal the individual. No healing system is isolated, but is influenced by diffusion of ideas, change in cultural climate, emigration, politics, resources and technological advancement. Exchange and change influence approaches to medical treatment of the ill, which, in turn, creates a climate of medical pluralism as ideas and methods achieve or fail to achieve broader acceptance.

Medical Anthropology is rooted in an interdisciplinary approach to research, and incorporates elements of physical anthropology, ethnomedicine, psychological anthropology, epidemiology and international public health. The primary objective of medical anthropology is to look at disease and culture (i.e., behavior and beliefs) within a

specific ecological context. According to Fabrega (1999), all societies exhibit a socio-culture of healing, and therefore a disease theory system to accommodate the particular world view operating in that culture. Informing the world view are macrosociological factors such as ecology, politics, environment, social organization–all of which are tempered by the unique cosmology governing attitudes and behaviors in general. It is the medical ecological framework that most represents the holistic and interdisciplinary nature of medical anthropology. By focusing on bio-environmental, clinical, epidemiological and socio-cultural aspects of healing systems, one may construct, predict and examine disease causation, and incidence in relation to social processes.

Within the field of medical ecology is the subfield of nutritional anthropology. This discipline incorporates human behavior and social organization and within this context examines the nutritional status and growth of a given population. Of additional importance is the symbolic and structural place food has, which informs analyses about consumption (Recommended Daily Allowances etc.), proscriptions, taboos, and general dietary proclivity.

Because disease theory systems are culturally determined, emic and etic perspectives must be taken into account to study medical phenomena. From an emic standpoint, depending on the population being studied, disease causation may be rooted in social phenomena–the result of taboos being broken, sorcery, failure to follow dietary prescriptions, or a host of other transgressions leading to illness. In contrast to this is the clinical view of disease causation, in which disease is a separate entity and treated as such. When these two systems (emic and etic) are at odds, conflict between

epistemologies may result. In his study of Bolivian ethnomedicine (*Drum and Stethoscope*), Bastien (1992) suggests a means of negotiating relevance in medical care, whereby the biomedical model takes into account the indigenous ethnomedical model, to create a more harmonious and efficacious strategy for tackling health care issues. Spring (1980) also notes that in some cases traditional healers have much to offer in the way of assistance to primary care physicians. Implicit in this approach is a sensitivity toward various socially constructed features of illness, such as the "sick role." With the institutionalization of this sick role, the doctor-patient relationship has become characterized by medical dominance as the sick person abdicates power.

Romanucci-Ross (1997) and fellow contributors address the issues of medical syncretism, pluralism, and strategy for indigenous populations who find that they are politically, economically and socially at odds with the encapsulating health care policies. As Brown (1998), Hahn (1995), Kleinman (1980), Romanucci-Ross (1997) and others have noted, in medical anthropology illness and disease are two distinct concepts: illness is the personal, cultural, social concept–an active condition a person experiences as a departure from good health, while disease is the objective, diagnostic, biomedical explanation of an ailment (Helman 1994). Brown (1998:7), asserts "the basic difference is between objectively defined disease based on clinical signs and the patient's perception of not being well and having an illness" [a culture's reality is socially constructed]. It follows that in most societies there is some type of disease theory system with associated specialists, treatment, and even an accepted "language of distress." Not only is the latter a product of the language itself, but also of the underlying belief system–the values most

important when promoting health and healing. Accordingly, all systems have a built-in mechanism for addressing deeds/activities, which bring on illness (e.g., sorcery or the evil eye for a personalistic system; or avoiding hot/cold proscriptions in a naturalistic/humoral system, see Foster 1976). Complicating the picture further are certain cultural and socio-economic factors that influence preferences, attitudes, activities, and therefore health status.

In terms of the biomedical model, there are a number of health status indicators that are used to help determine the rates of morbidity, mortality and nutritional status within a given population. The following indicators are referred to in this dissertation and are defined by the World Bank Country Reports on Health, Nutrition, Population and Poverty (2002) as:

Infant Mortality Rate (IMR): Number of deaths x 1,000 per year divided by the number of live births that year for children under 12 months.

Percent of Children Stunted: Percent of children whose height measurement is more than two standard deviations below the median reference standard for their age as established by the World Health Organization, U.S. Centers for Disease Control, and the U.S. National Center for Health Statistics.

Percent of Children Underweight: Percent of children whose weight measurement is more than two standard deviations (moderately underweight) or more than three standard deviations (severely underweight) below the median reference standard for their age, as established by the above organizations.

Percent of Mothers with Low Body Mass Index (BMI): Percent of women whose BMI is less than 18.5, where BMI is defined as weight in kilograms divided by the square of height in meters. [BMI=weight (kg)/height $(m)^2$]

These diagnostic tools may be good indicators of health status within a given population, but often the "traditional" medical system (approaches which incorporate culturally

significant perceptions about the body, resources available to implement treatment, and personnel available to make diagnoses based on the above) is incompatible with the biomedical explanatory model. Some points of contention may include definitions of what constitutes illness as well as emotional factors brought into the equation such as guilt, avarice, shame, immorality, social "incorrectness" (e.g., deviant behavior or the breaking of taboos). In terms of defining the disease, adherents to clinical medicine recognize that an affliction may be present with or without the patient's express knowledge (e.g., diabetes, hypertension). In some groups, since illness is viewed in terms of well-being (how a patient actually feels), if symptoms are not present, then the patient is well. On the flip side, some groups define social and psychological phenomena in terms of illness (e.g., culture bound syndromes such as *susto* (spirit possession) and "high blood" among some South American groups). (see also du Toit 1997 for a discussion on culture specific illnesses). Furthermore, the patient is viewed in the broader context of his social and familial relations and cannot usually be extracted from the community. Relationships are paramount, and treatment usually takes on a more holistic and socially significant approach in traditional healing systems.

Another distinction between cultural illness and clinical disease, is the so-called "language of distress." As clinical medicine takes the front line in many countries, greater sensitivity needs to be given to those patients for whom the technical language is not understood. This is a problem in "modern" and "traditional" communities alike. Because in Medical Anthropology medical systems are explored cross-culturally, disease theory systems must be better understood to gain insight into culture specific treatment of

the ill–within a healing domain a particular "language of distress" with associated treatment and paraphernalia that enables the healer to eradicate illness. Accordingly a disease theory system should be able to explain: 1) the cause of the illness, 2) the logic governing disease etiology and treatment, 3) how and if the above has a bearing on social relationships, and 4) consequently what must be done to restore social harmony and balances. With factor three in mind, it becomes apparent that a disease theory system plays an integral part in the maintenance and sanctioning of social norms within a given social system. It is then the objective of medical anthropologists to negotiate the relevance of such systems within the broader context of their health status. As Young (1976) notes: "Because a people's beliefs and practices about prophylaxis, diagnosis, and therapy constitute the greatest part of any society's efforts to understand and deal with sickness, they must be the indispensable *material prima* of the anthropologist who wants to study sickness."

The Theoretical Stew

In terms of theoretical orientation, my approach to research was most in line with the medical ecological model: I looked at clinical, social, epidemiological and environmental features contributing to the health status of *gecekondu* dwellers. But I did borrow from other camps, such as "Critical Medical Anthropology" as I looked at power and agency among the various health care sectors (and their recipients) in Turkey. My conceptual framework is also driven by an interest in pragmatism and survival, which would hearken back to F. G. Bailey's model of social action (see Bailey 1969)–whereby

the normative rules governing society are obliquely and pragmatically arrived at by individuals to achieve optimal personal advantage.

Conclusion

It is commonly accepted that pluralistic systems of health care occur in most of today's societies. While the western biomedical model for health care may tend to dominate most working systems in the modern world, other systems work concurrently, and find various degrees of success among the populations who use them. In order to understand disparate ideas about disease etiology, as well as the persistence of some types of preventable diseases in a given region, one must take a closer look at cultural, ecological and political variables. The medical anthropologist is in a unique position to provide a bridge of knowledge between disparate medical paradigms.

CHAPTER 3
METHODOLOGY

Introduction to Research Design

The purpose of this dissertation is to explore the concept of medical pluralism, as it relates to a sample of Turkish migrants residing in one of the squatter settlements in Istanbul. To garner this data 119 short interview schedules were conducted primarily among women in the Ümraniye *gecekondu* of Istanbul (characteristics of the *gecekondu* are discussed in chapter 4) (Figure 2). These interviews form the core of this study, and contributed to my understanding of household economy, strategies for treating illness, attitudes about religion and politics, and nutrition.

Four in-depth interviews were conducted with medical professionals, who provided me with their personal views about primary health care in Turkey, and also gave me some insight into the administrative and social problems with which they are faced on a day-to-day basis.

Four informal interviews were also taken with various other medical professionals (nurses and hospital technical staff). These individuals provided me with information at the medical support level, and gave me an insider's look at operations behind the scenes. Additionally, twenty-nine short interviews were conducted among pharmacists in the Ümraniye area. These interviews provided information about the incidence of over the counter drug use and abuse, and also a look at the pharmacists' attitudes toward their

customers and the medical system in general. Two open ended interviews were taken with Ümraniye community Imams (religious leaders) in order to gauge the extent to which the community leaders are involved in health stress problems of their constituents, and also to gain a better understanding of some of the complaints and

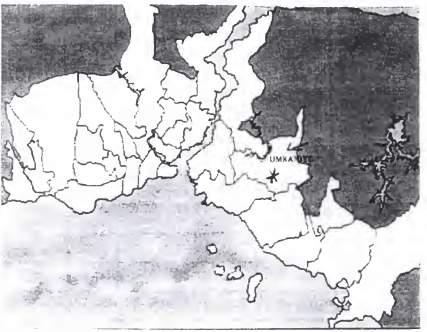

Figure 2 Istanbul by District (Umraniye Marked)

problems facing *gecekondu* residents. In the religious sector I also met with a *hoca* during one of his healing sessions and spoke with him (via his wife) about the services he performed for Ümraniye women.

To round out the perspectives of health personnel and the people they serve, two interviews were conducted with herbalists (in addition to informal reconnaissance at various herbal shops in Istanbul). These interviews were important in that they provided me with access to those remedies and treatments recommended to their patrons at the folk/popular level. Finally, four months of observation at a local public health clinic

informed this study. My main goal in speaking with this diverse group of people was to find representation and perspective among the various health care sectors available to my core research group, the women in the *gecekondu*. Further to this goal, I examine some of the theoretical aspects of decision making in a given health care system–which is a creative process, involving personal inclination, economic factors, social status, gender, religious affinity, and governmental resources.

At the core of this study was the question: what is the order of resort for lower SES *gecekondu* women when making decisions about health care and treatment. A review of the literature within this topic led me to surmise that when economic resources are scarce, individuals may utilize alternative means ("traditional" methods, home remedy, etc.) as a pragmatic strategy, since the normative channels are limited to them. According to du Toit (1998), "Conditions of economic and social deprivation among aged Coloureds in South Africa have resulted in reactivation of traditional beliefs and practices involving folk medicine." My aim was to find the extent to which this is true among the Ümraniye residents.

Upon speaking with various personnel and individuals among the sectors I examined, it became apparent that a stigma is attached to those who embrace concepts which do not fit with the "modern" and "secular" approach to health care, i.e., the western biomedical model for treatment and preventative care. Therefore, using triangulation as a general approach to understand the nuances of attitude, I tried to discover the truth about the actual practices of the *gecekondu* women when it came to health care. Because this is not an isolated concept, but is influenced by a host of other

factors, special attention was also given to religious beliefs, personal agency (base of knowledge about treatment of ailments from the emic perspective), and also how these attitudes are interpreted both within the professional sector and comparatively among the *gecekondu* women.

Gecekondu Sample

The women of Ümraniye *gecekondu* in Istanbul make up the core sample of this study of medical pluralism. This particular settlement was chosen for a number of reasons: 1) Turkish colleagues and friends independently mentioned this area as a good site to find out about health care issues of women; 2) the clinic where I did observations was within the catchment area; 3) this was one of the more economically disadvantaged areas, and therefore of interest to me since the focus of this study is medical pluralism among lower income groups. The sampling method was conducted in a quasi-random way within an area of Ümraniye called Kazim Karabekir Mahallesi (Figure 3). The infrastructure ranged from well established older dwellings, to quickly laid brick box houses with temporary roofs. Residents of this area were willing to speak with me openly about a wide and deeply personal array of topics, and most of these women opened their door to me with true Turkish hospitality. Justification of a single gender sample for the bulk of these interviews lies both in the realm of practicality (access to the community as a foreign female, and given that my interviews were all conducted in the daytime) and at a more in-depth level due to the status of women in the household, and in particular their position as care takers of the family this group suggested they would be

the most logical and information laden targets. In terms of age, no boundaries were set beyond the fact that all the women I interviewed were adults. The youngest interviewee was 17 years old, and the oldest was 80, providing a good range of perspective between generations. These changes over generations proved to be a valuable indicator of change and socialization among Istanbul migrants. The sample of respondents consisted of 119 individuals. For this aspect of the research project, a semi-structured interview schedule

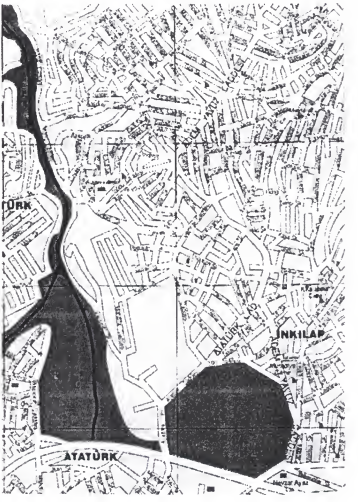

Figure 3 Kazim Karabekir (Upper Right Block and North)

was employed (see appendix A) by myself and a female research assistant (a native Turkish speaker). Using a multi-format short interview schedule, questions were asked of individuals to determine their attitudes, biases and hopes with regard to economics, religion, health strategy, nutritional intake and politics. Questions were grouped into five different sections, each of which was geared toward gaining an understanding of general attitudes and strategies, and also the real state of the household economy for those families studied.

The Clinic

Another aspect of health care important to this study, was the use of public health care facilities among the Ümraniye *gecekondu* population. For this reason, I chose a health clinic in the "Atatürk" region of Ümraniye–the main public center (though smaller satellite clinics were situated in various other regions of Ümraniye, which is located on the Asian side of the city). In this clinic, which provided pre- and peri-natal care for mothers in the family planning unit, and serviced all other sectors of the population as well, I was able to "sit-in" on a wide range of medical visits and confer with the attending doctor throughout the process. I spent several months engaged in this activity, and was able to observe doctor-patient relations, communication, common complaints, patient agency, and the conditions under which a physician must work at the public health care level. Both male and female patients were observed in the clinic setting. A male research assistant (Kaan) accompanied me and took notes in Turkish, as I took notes in English, and at the end of each session we compared our notes and observations. Kaan

was also the photographer, and provided many of the photographs contained in this dissertation. Additionally, between patients I was able to get a summary of the previous patient's medical history and current complaint and treatment by the attending doctor. The doctor was a gregarious sort who enjoyed being the focus of this study, and took great pains to explain the procedures and activities within the clinic to me.

Herbalists

In order to get an idea of some of the herbal *materia medica* available to the population, and also alternative healing practices, I interviewed two professional herbalists about their clientele, their products, and their opinions about alternative health care in Istanbul. My main source for personnel of this sector was within the *Misir Carsisi* (Egyptian Bazaar) located in the heart of Istanbul in an area known as Eminonu. In addition to those herbalists working in the *Misir Carsisi*, I interviewed the proprietor of a botanical shop in another section of town called Kadidoy. Interviews were conducted in an open-ended free style fashion.

Pharmacists

To better understand the extent to which over the counter medications are used by the core sample, I interviewed twenty-nine pharmacists about their experiences with their clientele, their opinions about OTC (over-the-counter) and prescription medications, and the demographic profiles of their patrons. Pharmacies were chosen, again in a quasi-random sampling fashion according to proximity to the Ümraniye catchment area. The

interviews were structured, and consisted of twelve open ended questions designed to provide information about use and frequency with regard to some common medications, as well as attitudes toward their clientele. Additionally, since a crisis among the Union of Pharmacists was going on at the time of this research, questions about the union complaints and activities were asked. I also attended a scheduled demonstration the Union of Pharmacists staged to get the attention of higher ranks within the Ministry of Health and the general public about work conditions and dissatisfaction with governmental policy with regard to tax, foreign pharmaceuticals, and loss of profit.

State Hospitals

Two state hospitals were toured and "staked out" in silent observation, so that I might gain a better understanding of the infrastructure, technology, amenities, professional attitudes, and organization associated with these facilities. Two different types of hospital were chosen: the first was Hydarpasha *Hastanesi* (hospital), which is associated with Marmara University (one of Istanbul's general education and medical universities), and was accessible to me because of my acquaintance with the director of public health services at the University. The second hospital I toured (also upon recommendation of this colleague) was a new facility, which was specialized in cardiology. This facility was chosen for two reasons: 1) it was a new and state-of the-art "showcase" hospital, and quite advanced compared to other state hospitals, and 2) Turkey has one of the highest rates of heart disease in the world, and I wanted to get information about patient profiles and treatment (see Onat et al. 1997 and Hergene et al. 1999). Since

the medical and technical staffs at both facilities were stretched thin for time, I "shadowed" them on their rounds, and conducted interviews in a free style fashion. Additionally, at the Hydarpasha Hospital emergency room, I hung out at the triage center and observed patient-doctor interactions.

Interviews with Medical Personnel

In addition to those interviews conducted with the state hospital doctors, I interviewed the public health director at Marmara University (Dr. Dilek) several times, once informally over lunch, once on the telephone, and once in a structured face to face interview. Additionally, I was able to speak with medical interns and researchers associated with the Atatürk clinic (a public health facility located in Ümraniye. where I conducted my interviews among *gecekondu* women) and the Marmara University public health department. Two of the doctors I spoke with had been doing a contraceptive outreach survey in association with Johns Hopkins University, and I accompanied them on their follow up rounds around the same Ümraniye *gecekondu* area where I conducted my own research. Additionally, two semi-structured interviews were conducted with the head doctor at the clinic, Dr. Ali, who was also a specialist of Health Management Organization. His candid insights provided a great deal of information for me, from an insider's perspective.

Imams and *Hoca*

In order to understand the religious dimension of health care and community, I interviewed two Imams who worked within the Ümraniye *gecekondu* of my research focus. These interviews were conducted after Friday prayers at the mosque. We conducted the interviews outside the mosque, with my assistant Kaan doing most of the prompting and questioning (Kaan was coached about the intended content of the interview before hand, as it was more appropriate for him as a Turk and as a man to speak with these Imams.) Finally, upon discovering the identity of a *hoca* in the Ümraniye area, I was permitted to observe healing rituals and general household activities in his home.

Positionality

Anthropologists generally agree that entry to the field site can be problematic. Establishing rapport with a group when one is in every way an outsider presents many challenges to the field researcher. There are language barriers to contend with, closed social networks, even tighter knit family structures, landscape, politics, religious, racial and gender arrangements which often prohibit an outsider from the intricacies of that system. Since the basis of field anthropology is participant-observation, these challenges are cause for much personal angst, and often a re-evaluation of one's time frame (to wit: making it more realistic, which often means a lengthier process than one had envisioned). To make at least some of these issues less problematic before I got to the field, I established my professional connections and selected research assistants while I was in

the United States (via the internet). By liaising with the Director of Public Health at Marmara University, I was able to gain clearance to do the clinic observations. This correspondence also led to connections with other doctors and medical interns, who enabled me to gain various perspectives about work conditions in Turkey, and also provided me with access to the state hospitals. Establishing rapport with the *gecekondu* women was somewhat more problematic. These areas had been the object of outreach programs and other studies of sociological interest in the past, and there was a jaded attitude toward outsiders with their clipboards and questions that I had to overcome.

Data Control and Management

Literal transcription from taped interviews, field notes, photographs, archival materials, newspapers and other print sources, as well as responses from structured and semi-structured interviews were used to analyze the data in this dissertation. The main approach is qualitative in nature, so field notes gained from private observations, quotes from various participants, and supplemental archival and source materials were of supreme importance to me. For the quantitative portion of this analysis simple statistical calculations (long hand) were sufficient, and where the subject matter was a little more complicated to organize, the spreadsheet program Excel was used. Photographs were taken (by my assistant Kaan and myself) throughout the process, and used as a visual aid.

Summary

A multiple strategy methodology was used to collect the data for this dissertation employing qualitative and quantitative approaches: scheduled observation, participant-observation, print sources, structured interviews, facility tours, short interview schedules and impromptu interviews, along with state statistical data. The purpose of this study is to determine the extent to which medical pluralism is used as a strategy for health care among those residing in this lower socio-economic sector of Istanbul. For this work, the area of Ümraniye was chosen for several reasons. In terms of infrastructure and population, this region represents one of the most underprivileged areas of Istanbul; in terms of history, this region is host to both long term settlers and to new waves of immigration; in terms of community and social networks, these points were easily discernable; and in terms of accessibility, the individuals were willing to participate in the study. As a specific point of interest (in terms of medical pluralism, or as Romanucci-Ross describes it, "order of resort"), the degree to which traditional approaches to health care are still used along with home remedy and so-called "modern" clinical methods was assessed. Results of this study show that urban assimilation of domestic migrants forces a slow re-evaluation of folk methods for dealing with health concerns. In addition to the condemnation of traditional healing practices by the upper SES population, a discernable self-consciousness on the parts of *gecekondu* study participants points to a pressure to conform to the acceptable cosmopolitan attitudes toward a health care strategy. With this in mind, another noteworthy aspect of this study was the difference between what Onder (1998) referred to as "frontstage" and "backstage" behavior among medical personnel

and their patients. This distinction between public and private behavior was an intangible but problematic area in my quest to understand attitudes about health care among my sample in the *gecekondu*. Kutsche (1994) studied a number of factors that guided individuals who migrated from rural Costa Rican areas to a primate city. He itemized a number of anthropological assumptions about migrants and their circumstances; and yet he found that among the more statistically significant data regarding push/pull factors and other economic variables, personal agency, character, personality, disposition, and ability to cope with stress all contributed to the ways in which individuals dealt with life moves and migration–a reminder of the more idiosyncratic nature of change at the individual level. Of particular interest to me, vis-à-vis my own study of the *gecekondu* migrants, was the difference between "ideal" and "real" expectations and experiences. In order to arrive at the elusive truth, one must read between the lines, and examine the individual's life situation from various angles. As I read over the interviews, I became increasingly suspicious of broad interpretations of migratory movement and more acutely aware of the idiosyncrasies of each individual's case. It is tempting to look at trends in movement and economic station in blanket terms (kin pulling them into the circle of economic opportunity, e.g.), but beneath the surface are individuals whose motivations are highly subjective, and successes or failures equally so. While the systems theory of migration may focus on the distinction between "active" and "passive" migrants (i.e., those who initiate a move for economic and social profit vs. those who follow the initiators, see Mabogunje 1970), at the individual level, personal motivation extends beyond the neat system and incorporates personal desires, situational dynamics, and personality, among

other factors. When looking at attitudes toward health care, these "public" and "private" behaviors and attitudes are equally revealing. Often a statement will reflect normative expectations, while at the pragmatic or strategic level the ideal is left behind for a more realistic, "sensible" or accessible action.

CHAPTER 4
THE *GECEKONDU*

Introduction

Istanbul, Turkey was chosen as my site of inquiry primarily because it is host to a diverse (both socially and economically) population. The focus for this study was the health status and strategy of groups living marginally in the shantytown or *gecekondu* (meaning literally "built over night"). Thousands of Turks live in a kind of economic limbo in the shanty-towns of Istanbul and other large cities. Villagers who migrated into urban areas to seek out financial opportunities usually occupy these gecekondu. Along with thousands of others who live in rural Turkey, a conflicting ideology survives in spite of enforced secularism (Finkel and Sirman 1990), and therefore repercussions may be seen as residents strive to become integrated into urban life.

Srinivas (2002) marks three essential traits characteristic of squatter settlement: 1) The infrastructure is substandard (e.g., housing development and public works are not adequate by urban standards); 2). Squatter residents are usually migrants, though second and third generation migrants may also continue to reside in these areas; 3) Most squatter developments are built on marginal areas of the main urban center, and 4)These settlers have built their dwellings on someone else's (or state owned) land. In the case of the Ümraniye *gecekondu*, many of the residents had, over time, passed from temporary to permanent and had become legitimized, as settlers had passed from a "squatter's" status

to that of homeowner. Isik (1997) states:

> The 1980's was a period when the *gecekondu* became increasingly co-modified and ceased to be a solution for the masses migrating to the cities. This was a period when, initially a land market and, later, a construction market devoted entirely to the *gecekondu* appeared. The practice of users building their own houses ceased to be the norm. Soaring values of *gecekondus*, as urban properties, encouraged some *gecekondu* owners to pull their original houses down to build multi-story ones. The additional units thus obtained were either sold or offered for rent. Concomitant with the decreasing rate of owner-occupiers was an observable decline in environmental standards.

And further:

> The outskirts represent the side of the growing polarization that has increasingly come to dominate Turkish cities, watched from afar. The logic that held urban populations together is now rapidly disintegrating and the squatter areas in the cities are turning into inward-looking communities.

With the increasing marginalization of these areas, it is important to understand how and if they fit into the community as a whole, and further whether or not they are able to benefit from governmental resources awarded those residents who are established in the legitimate residential areas (see UN Reports 1998 and 2000). While Istanbul is host to a number of these regions, my focus was, as mentioned, Ümraniye, which is located on the Asian side of the sprawling city. The Ümraniye area is subdivided into a number of districts or *mahallesi* (pl.), each with discernable differences in superstructure, economic viability, and social cohesion. For the present study, the district of *Kazim Karabekir Mahallesi* was chosen for several reasons: It is host to some of the most disadvantaged sub-populations within Istanbul, the individuals within were willing to participate in this research, and in terms of geography and isolation, the region represented a neat enclave of neighborhoods, and a degree of social cohesion which made the area interesting to study from a network standpoint.

Migration and Social Roles

The issues surrounding migration — particularly rural to urban migration — are of a broad scope. When analyzing population movement, one must take into account the processes, and the circumstances, surrounding not simply the collective, but the internal and individual motivations of those people. One must recognize the various types of migration that occur (foraging, circular or permanent) to benefit the individual, as well as the repercussions — if any — on the group as a whole. Furthermore, one must look beyond the convenience of statistics, to the depth and scope case studies provide (du Toit 1975). Kutsche (1994) spoke with a number of migrants in Costa Rica, and made some interesting points regarding this distinction. In particular he found that just because individuals have similar backgrounds and economic status, it does not necessarily mean that their successes or failures will be identical. Personality, inner drive and life experience all contributed to the outcome. Of additional interest is whether or not migratory processes are forced or voluntary. Regarding involuntary movement, Parnwell (1993) categorizes the phenomenon as "impelled movement," which may be due to circumstances such as warfare, civil conflict, natural disaster, etc. du Toit maintains that even in the face of adversity, there is always individual choice. Jong and Gardner (1981) concur, citing the individual, family or household as the basic unit of study for such movement. Voluntary movement has many motivating influences, and may be analyzed using a "decision making model." Du Toit (1975) refers to a "multi-causal nexus," which encompasses the range of complex factors that influence population movement — stimuli such as economic need, domestic stress, and networking, among others. In order to

understand the breadth and scope of this interaction, one must consider the ongoing interrelationships among these determinants on concentric levels — a rippling effect.

Of particular interest to the anthropologist, is the study of migration from rural areas to urban centers. Du Toit (1975) addresses the types of migration, which can occur in this category, such as seasonal and permanent migration, as well as that of the "repeater." Though it is dangerous to apply a blanket model to a given phenomenon, the decision-making model is flexible enough to encompass a realistic array of variables. Again, case studies provide a neat unit of study and bring the causal/individual element into focus.

In Turkey, historically, marital laws reflect a social need to protect genealogy and property. A shift in values and household gender relations is a phenomenon that pervades urban migration movement—at the theoretical level—and is marked by the belief that once a group or individual moves out of his/her natal village a modification of the social network occurs. One may see evidence of this as this has been described as a move from the extended family format to a nuclear family in the urban environment, or perhaps a cessation of filial obligation, truncation of the family in general, with women choosing to engage in stricter birth control, and a reassessment and reconfiguration of the social network. In Turkey, there is some truth to the urban-rural dichotomy, and there are also some misconceptions. This can be seen, in particular, among inhabitants of the *gecekondu* of Istanbul (Karpat 1975). Karpat describes several features that should be differentiated in order to lend understanding to those studying the migration event. In general, there are "push" and "pull" factors, which lead a person to migrate. The push

may be lack of resources, lack of money, breakdown of the kin network in his natal village. Accordingly the "pull" would be the possibility of earning a better wage, having a better lifestyle, or perhaps to be free of one's filial obligations. In terms of migration and the transition from a "peasant" lifestyle to an urban lifestyle, this has some repercussions for family and individual.

Interestingly, there is a structural parallel between rural and urban social organization. In rural life, an extended family is the norm. Virilocal residence patterns dictate that a woman should reside with her husband's family, and therefore, this family reaches several generations in both directions. The cohesion is a function of social and familial obligation, loyalty and economics. In the urban environment, one may see what appears to be an extended family situation, but which is functionally present for reasons other than family/filial obligation and resident/descent laws: economics is the basis for much of the structure among city dwellers who have migrated from rural areas. Due to residential realities, neo-local residence becomes the rule. Often an individual is "sent ahead" to the city to establish a foothold and residence.

Generally, those with economic constraints are directed to the *gecekondu* areas, where municipality loopholes make it possible to literally erect a house over night without the threat of eviction or costly taxes. These dwellings are literally built out of available materials–sheet metal, loosely assembled bricks, plastic and the like (see Figures 4 and 5). This makeshift dwelling serves as a stopgap habitat, while the migrant looks for work and establishes a social network in the new city environment. Often, he is influenced by individuals from the same village (or vicinity), who in turn advise the

individual about job opportunities and other resources. Thus, though a new social network is in the making, this is really a kind of transitional status, for which feedback loops to the natal village–ties to kin–are still in evidence. The migrant may send back for brothers, or other family members, or he may eventually return to the natal village. There

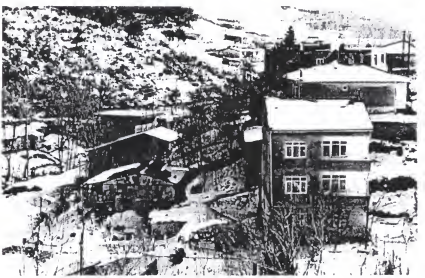

Figure 4 The Umraniye Gecekondu in January (2002)

Figure 5 Interior of a Home in Kazim Karabekir

is therefore a duel system at work. It is really a type of flexible social organization, where elements from rural life are superimposed onto urban life (with innovative adaptations), and conversely where urban attitudes and practices are in turn translated to resemble rural life, and transform rural attitudes.

Traditional Social Organization

As mentioned, there is a system of medical pluralism throughout Turkey. Istanbul is one of the largest cities in Turkey, and is therefore host to an ethnically, socially, economically diverse group of people. In terms of social stratification, the highest political officials reside in the affluent areas of Istanbul; the poorest and most thoroughly alienated live in other sections of the city. Most visible of the latter category are the street children who live beneath the pedestrian walkways and steal and beg for a living. Between the two extremes one may stop at every locus on the socioeconomic continuum.

Though Turkey promotes a national image of enlightened Western-style democracy, and individualism, an undercurrent of traditional social organization and sentiment is still very much a part of the social makeup of its citizens. Though there are some differences, depending on region, economic situation, education, and ethnicity, there is a traditional feature–peasant social organization–that tempers life and decision-making in Turkey, regardless of one's social orientation. Even the wealthiest, and most "Western" families of Istanbul and Izmir, are bound to be grounded by relationships or at least remote links to a traditional social structure (see also Kagitcibasi 1982).

Several features characterize peasant social organization in Turkey. First and

foremost it is said to lean toward agnatic descent laws, and virilocal post-marital living arrangements. Traditionally it has been appropriate for a woman to leave her natal home and live in that of her husband, with his family until such a time as the husband's father died. This marks the point at which land would be divided among the sons. Traditionally, a woman's "worth" was in her work and reproductive power, for while Turkish laws and even Quranic laws provide inheritance for women, the de facto situation is that sons/men are the primary recipients of land inheritance (Ilcan 1996). Therefore, in the past, and particularly among tribal and traditionally sedentary communities, a bride wealth (*baslik*) was provided. In terms of kinship terminology and structure, the traditional Turkish peasant structure corresponds to Sudanese kinship system, whereby nearly all individuals within five steps of ego are differentiated by different kin terms. Ego relates to maternal and paternal kin differently, and also with regard to age sets.

In addition to the patrilineal descent rules, the village as a whole is characterized as a closed corporate community (Stirling 1953). Those residing within are interdependent, and indeed a general preference for men to select wives from within the village further links families and domestic units. Each unit is referred to as an *aile*, which connotes domesticity and loyalty. Because the preference is for in-village marriage, the virilocal living arrangement is believed to be not as stressful for the women (when compared with brides having to relocate) who are not forced to sever ties completely with their families. The actual situation is of course variable. New wives (gelin) are the lowest ranking members of the household, and are subordinate to their mother in laws.

They are also responsible for much of the brute labor, and are expected to bear children right away, and also to care for the ill within the family unit. Though Delaney (1991) mentions a general penchant for marrying patrilineal parallel cousins in the Middle East (FBD marriage), in Turkey this is currently considered an outdated notion, practiced more among the most rural inhabitants of Turkey. In fact, Delaney (1991) and McCabe (1983) note a markedly higher rate of divorce with lower birth rates among such couples (FBD marriages). Regardless of kinship practices affecting consanguineal relatives, the real social unit is the village. Within it loyalties are subtly connected between households–whether segmented groups related agnatically, or connected fictively.

With regard to social support, Stirling (1953) and Magnarella (1972) both looked at some interesting features. Stirling reported on social behavior and the ongoing blood feuds in the village he studied, while Magnarella looked at ritual kinship as expressed by the practice of *kivrelik* (circumcision sponsor) in southeast Turkey (both of which focused on the male experience). Stirling's observations of vendetta in a Turkish town were illustrative of the expressions of loyalty between kin groups. He described how an incident was escalated and called for members of various households to respond to defend the honor of the transgressed. A woman, washing her grain at the public square, was insulted by a man from another household, and slapped. The woman's husband was away on military duty at the time, and her family–as well as those who supported the family from other households–rallied around her to show the man his error. This was done in a number of ways: one way to let a person know where they stand is to insult livestock within earshot of the one for which the insults are really intended. In this way

the confrontation is indirect, but lets the transgressor know what is felt, and which families are behind the individual.

Magnarella described the social obligations surrounding *kivrelik*, which is a kind of sponsorship for circumcision–obviously for young boys (Sertel 1971 also likens this to *compadrazgo*). When one accepts such sponsorship he gains a ritual status of kin, and is therefore obliged to act in a loyal and responsible manner toward his ward's family. He notes that socially this confers a kind of "godfather" status that one sees in many Latin countries. Should segmentation occur, though family units may then move in different circles on a day to day basis, when a crisis erupts, these units come together and form a solidarity. Therefore, though blood ties are the more obvious form of social cohesion, a number of subtle factors, in the form of fictive kinship and social alliance are invoked to create a truly interdependent corporate community.

Geographic Profile

In terms of geographic profile, the area I sampled in Ümraniye is fairly heterogeneous. Out of a quasi-random sample of 119 individuals, natal residence ranged from southeastern Turkey to areas along the Black Sea, and back to Istanbul, with everything in between these points. Therefore, the usual enclave situation one hopes to find with regard to familial and kin networking was not a working factor in the present study. However, it is interesting to note that while the purer form of Meyer Fortes (1969) "axiom of amity" was not in place, a more pragmatic channel to this "axiom" exists by virtue of the fact that all are settlers seeking a better lifestyle and this provides an

umbrella of commonality for these people. While familial and geographic origins may differ greatly, the one great equalizer is economics. For most of the people settling in the *gecekondu*, economic pull is the driving force behind migration. In all, from this sample, a total of 40 cities were represented (two of which were outside of Turkey–in Azerbaijan and Bulgaria respectively). Therefore in terms of percentages, there was a fairly uniform 2.5 percent represented by each natal city or village. In a way this makes the axiom of amity all the more interesting. Women and men from vastly different social and geographic circumstances are thrown together. While this would have been a somewhat alienating factor back in the natal town, the new situation these groups find themselves in, on the margins of Istanbul makes the cultural and religious ideals, conservative background, and economic similarities a common source of amity. In terms of integration with the outlying city of Istanbul, this provides a buffer not unlike what one would find in a true enclave situation in which family and relatives are pulled together by economic necessity when migrating.

Economic Perspective

According to the Turkish Daily News (TDN) (June 3, 2001) the gap between economic classes has gone from bad to worse as the lower SES classes become further marginalized and those with the means are able to seek opportunities outside of Turkey to bolster income. According to this article by the TDN average monthly income for the lower classes (nearly 50% of the population) ranges from only 50 million TL to 200 million TL (1.300.000 TL to U.S. $1.00). On the opposite side of the continuum is that

of the upper classes, who on average may gross up to 2 billion TL. With this economic gap, very little exists of a true middle class, with little hope when one is relegated to the lower class of aspiring to economic security afforded the upper economic levels. It is also noted that, "health services are the main problem for those of the lower middle class. The limited number of state hospitals fails to give sufficient health care to the millions of people." Many with conditions in need of health care are subjected to long waits due to overcrowded/understaffed health care facilities–the result of which is often an escalation of what could be a treatable ailment (e.g., high blood pressure, cholesterol, or similar.) When one takes into consideration the economic gap, and the contrast between private health care facilities and state-funded institutions, it becomes a critical point to look at local attitudes and experiences concerning most prevalent health care problems among this class, as they are for the most part unprepared to meet the costs of quality health care expenses. In addition to "luxury" items such as good health care, the low-income levels seen among the *gecekondu* residents press basic needs. When one considers that a monthly grocery bill for a family of four may amount to 60 million Turkish Lira for quality food items, and the lower end of the income spectrum is only 50 million, one begins to see that basic survival is jeopardized. Add to that, expenses including clothing (a couple of million for a tee-shirt, 5 million for an inexpensive skirt); transportation (5 million a week, at the minimum, per person, if they must ride public transport); and finally utility bills and other monthly expenses. This leaves the average family in a negative balance.

Conclusion

Given the dual nature of migrant and urban ideologies in Turkey, an enduring conflict exists between these general lifeways. One sees in the *gecekondu* an almost desperate attempt to reconcile these differences publicly, while holding fast to cultural identity. This creates a greater conflict in terms of well being, and integration into the encapsulating urban environment.

CHAPTER 5
SECTORS OF HEALTH CARE IN TURKEY AND GENERAL SURVEY OF HEALTH STATUS LITERATURE

Introduction

In Istanbul, there is an outward antagonism (as seen in the media and general attitudes of Istanbul residents and on the part of the biomedical sector) toward ethnomedicine. In practice medical pluralism is in operation. For minor ailments individuals self-medicate. Mothers seek the advice of family and friends to treat their children. Herbalists, *hoca*(s) and older generations with healing skills are all sought as the first order of resort (and sometimes the last) instead of professional medical care.

In a related vein, professionalization of the midwife is the perfect example of an equitable solution–a bridge between worlds. The profession is comprised of women, most of whom have a history of this career in the family. They are aware of the historic importance of their professions, as are the women they service. However, by becoming certified by the medical community, they are able to adhere to standards acceptable to both communities. The pregnant woman can still give birth in the privacy of her home, with a midwife she can trust, and the medical community can be secure in the knowledge that the midwife practices hygienic and safe methods.

Istanbul has a population of some twelve million inhabitants (projected from the 1997 census at which time there were just over 8 million residing in the city of Istanbul), and unofficially some eighteen million people. The demography is heterogeneous and

economically stratified. The result is a disparity in access to and affordability of health care among those residing in this area, more specifically due to differential access to quality health care. While many studies have been conducted in Turkey, and particularly by Turkish sociologists (see Reed 1997), relatively few studies have focused on the folk strategies used by recent emigrant populations in urban areas. Medical pluralism is very much a part of medical/social life in Turkey today. Romanucci-Ross (1997) refers to the individual strategy at the center of medical pluralism as "the hierarchy of resort for curative practices"; and Kleinman (1980), more specifically describes the various levels of treatment, whereby one may choose from the popular, the professional, and the folk sectors. In fact, a number of health care practitioners are available: from the professional sector there are trained nurses, midwives and doctors (general practitioners and specialists such as oral surgeons, gynecologists, cardiologists, etc.) employed by state run hospitals and clinics, university and military hospitals, and private practices. These resources and personnel are available to those with either independent means, or health care insurance. It is more specifically available to civil servants, military, university personnel, and those employed by agencies willing to contribute to the health care costs. In a country of some 67 million inhabitants, this type of insurance does not cover about half of the population, and therefore medical treatment becomes a costly (and inconvenient) venture for those without it.

Additionally, the modern hospital centers are concentrated in the main urban areas (e.g., Adana, Istanbul, Izmir and Ankara). There are approximately 1500 people for every physician (4000 per dentist), and so even if one is fortunate enough to possess good

health insurance (or to live close enough to one of these cities), practitioners in this sector are severely under-represented, and therefore overworked, and less likely to provide a culturally meaningful exchange of ilgi–which can be translated as "attention" (see Onder 1998). However, for those living in rural areas the doctor to patient ration becomes even more strained. The result is an "order of resort" in action. For rural areas (as well as severely under serviced areas such as the *gecekondu*,) doctors are few and far between. Perhaps a "rung" down from these trained professionals, though still within this category, is the pharmacists. A wide range of medications, contraceptives and antibiotics are available in Turkey "over the counter"; therefore, the pharmacist has become a practitioner who does not always require medical referrals/prescriptions, and whose opinion is sought by those unwilling (or unable) to seek primary health care. This leads into the "popular sector" category. Through media, and therefore exposure to ads and information, one is able to "self medicate." There are a number of over the counter drugs, and through communication, word of mouth, media, experimentation, solutions are sought for minor medical complaints. A point of interest in the hospital system in rural areas, is that since hospitals are so understaffed, it is generally up to the patient's family to provide him/her with acceptable food, clean linen (in country hospitals), and so forth. Onder (1998) recounts numerous testimonies in which former patients describe negligence, and a less than caring environment. The result is a preference–among those of the lower socioeconomic sectors–for family health care; and indeed this is the first level in the hierarchy of resort for most people: the family. Within the family, women are the primary care givers, and among the women the mother is considered to be most

knowledgeable, while additional duties fall to the *gelin* (the daughter-in-law, literally the "one who comes" after the traditionally virilocal living organization in Turkey). Of course the degree to which these family "practitioners" are consulted changes from generation to generation. Onder (ibid) notes a marked disparity in attitude between the older and younger generations with regard to "home remedy." Older generations remember using various teas, compresses and foods to combat common ailments (fever, sore throat, cold, etc), and also various behavioral proscriptions to prevent their onset (e.g., wearing slippers in the house, avoiding cold beverages). Onder relates how one research participant (an 87 year old woman) described a method for breaking a fever: a small area of hair was shaved from the head (a central spot), and at that point the skin was "cut" with the razor and a blackberry ointment was applied. Today, she says, people go to the doctor for medical treatment, as the old ways have become obsolete. And yet there is still another sector that survives alongside the professional and popular sectors: the folk sector. In addition to trained medical midwives (known as *ebe*), there are traditional midwives (known as *koy ebesi*, literally village midwife). But even these are rapidly becoming scarce, as patients and practitioners become aware of professional liability. When they are used, it is usually in conjunction with the local health clinics, which follow up on a woman's progress. In the event of irregularity (such as a "breech" birth), the woman will be taken to the hospital, and clinic staff actively encourages women to have their babies in the hospital. In the past, the Turkish Medical Association noted a maternity mortality rate of 270 in every 10,000 births. Most common reasons cited were puerperal infections [in fact there are folk specialists who deal specifically

with this], toxemia and hemorrhage. Some practices, which were said to have occurred in the more rural areas, such as placing warm dung beneath the woman (while in labor) to keep her warm, and crouching over boiling water to release the after birth more quickly, contributed to those mortality rates. Especially in the case of "dung warmth" women often developed tetanus and died. These stories are in the public consciousness, and as a result, those with the means prefer hospital births (it is reported that some 80% of the private hospital births are cesarean because of the status conferred on the new mother, presumably an indicator of wealth and greater urban assimilation).

In addition to the *koy ebesi*, there are bonesetters. These folk practitioners are often the first order of resort for individuals who lack the means (and often transportation) to get to a hospital. The bonesetters are often maligned in the media and blamed for causing permanent and crippling damage; however, their expertise is still sought by young and old. The main technique used by these women is to apply a bee wax-soaked compress to the body (where it is suspected there is a break), and to massage the area where the flesh has "boiled." Interestingly, these practitioners possess their own "medical" terminology, and prescribe and dispense pain medication obtained from the local pharmacy. Therefore, those treated experience some of the outward "affect" of clinical medicine, but still get the *ilgi*. It should be mentioned that the bonesetter does, as Onder (1998) mentions, understand the limitations of this technique, and refers a patient to a medical doctor if the healer feels there is a serious problem. These two folk practitioners can be said to be of the secular variety.

There are also "sacred" practitioners in the folk sector. As Islam is the dominant belief system, there is an associated religiously significant technique for dealing with *nazar* ("evil eye" which is suspected as the underlying cause for many types of illness), as well as other supernatural forces. Prayer can be a very powerful therapy. An Imam (religious practitioner) and others who are well versed in the Quran may "read" passages over the afflicted, or else inscribe prayers or names on *muska* (amulets) to ward off evil and promote health. Often the *muska* is worn over the afflicted area (e.g., if the person has a headache, it is worn on the head [under a scarf]), or if it is a respiratory infection, it may be inscribed on a blue (the customary color to ward off *nazar*) piece of paper and worn around the neck.

A full range of medical personnel from all sectors of what Kleinman (1980) constitutes as a health care hierarchy, is seen in Turkey. While the population within Turkey is heterogeneous, an explanatory model for each sector of that population is in place. Causation, symptoms, treatment, medication, and pathology–all find a logical place within each curative option.

Some other types of personnel are the pharmacist, *hoca* and herbalist. Many of these have a corresponding practitioner in the United States. While our FDA and other administrative bodies provide fairly strict control over narcotics and related types of pharmaceuticals, over the counter medications offer a lot to choose from. A wide variety–less regulated–of medication is available over-the-counter. Antibiotics, oral contraceptive, mild narcotics, are all available. Additionally, according to existing studies on the subject (Onder 1998) the pharmacist is seen as a specialist for their

dispensation, and is actively consulted for this purpose (though this author found evidence to the contrary as shown in chapter 9).

There are many other areas of overlap, but one final one I'd like to mention is the "presentation" of doctor's offices. It is common practice to display a number of items in the office that may, at first glance, seem to suggest conflicting ideologies: posters about pre-natal care and nutrition, photographs of secular founder Ataturk, medical journals, and also: display cases with examples of local needlepoint, cases with Islamic journals and the Quran, banners with pithy and pious quotes from the Quran–in short a mixture of secular/standard paraphernalia, and more "traditional" Islamic and local flavors. This balance is sure to put the client at ease, and points to a flexibility of attitude, which is really the confluence of ethnomedical "sentiment", and biomedical "technique."

Epidemiological Considerations in Turkey: Survey of the Literature

In terms of overall nutritional status, studies indicate that inhabitants in the east are much worse off (nutritionally speaking) than are inhabitants in the south and west (e.g., May 1961). For example, in Erzerum (east, near the Georgian border), nutritional status of families is reported to be very poor, with a high incidence of rickets and osteomalacia. Gullu et al. (1998) speculate that since osteomalacia is a bone disease caused by vitamin D deficiency, and is usually seen more in countries with inadequate sunlight, the potential for danger in Turkey is due to cultural factors: in the more conservative rural areas of the northeast and southeast, women are expected to cover their bodies for religious and social reasons. Other "culturally-nutritionally" derived conditions occur throughout: in the northeast, scurvy occurs–the appearance of which is

seasonal and associated with long winters and low consumption of fresh fruits (May 1961). Pellagra has been reported in the Black Sea region--where there is a diet based largely on corn; and in the highlands, one finds--in spite of iodized salt campaigns--endemic goiter, a result of iodine deficiency (see Yordam et al. 1999 for a good discussion on the topic).

Another factor affecting health is that of social/political strife. In Turkey there has been an ongoing civil war--mostly situated in the southeast--between Turks and Kurds. In 1991, as a response to the Gulf War cease fire, and subsequent Kurdish revolt against northern Iraq, 500,000 Kurdish refugees settled in Turkey near the Iraqi-Turkish border (Turki Zakho Camp 1 is the refugee camp used for his study), have suffered an alarmingly acute degree of malnutrition and childhood mortality due to diarrheal conditions (Yip et al. 1993). Repercussions can be felt throughout the southeast, where many small villages have absorbed the flow of refugees--areas such as Diyarbakir and Batman that are more or less the seat of Kurdish/Turkish tensions within Turkey.

However, deficiencies and malnutrition are not restricted to refugee populations within the country. In examining blood vitamin and mineral levels in a general sample of Turkish children aged 7-17 years old, Wetherilt et al. (1992) observed "biochemical deficiency in 20% of the children for thiamin, in 89.9% for riboflavin, in 83.4% for vitamin B6, and 23.3% for foliate, 43% for vitamin C, and in 15.7% for zinc. Cholesterol levels were found to be above normal in 54.6%." The authors further report that the children were found to be relatively short according to the National Center for Health Statistics standards. Their normalized weights were within acceptable limits, which

suggested a prevalence of stunting but not wasting in this population. The authors surmise that a major cause of the above deficiencies was an ignorance of good dietary practice.

Tunbilek et al. (1996) found stunting to be the dominant expression of malnutrition when he examined over 3,000 children from five different regions in Turkey, with the greatest prevalence in the East. In adults, Aktan et al. (1984) looked at colonic function in rural and urban populations of Turkey. These authors found that rural subjects consume a diet higher in fiber than urban people in Turkey. Consequently, urban dwellers were found to have a rising incidence of fiber related diseases of the colon, such as diverticular disease not seen among the rural population.

The urban-rural variation is an important consideration when examining nutritional status. Such is the case of the present study of domestic rural migrants living in the squatter settlements in Istanbul. As can be seen from the survey of the literature, Turkey is a region in which folk beliefs persist. Though it would be a gross reduction to suggest that the rural-urban dichotomy is a neat one, one in which belief systems remain intact without diffusion of ideas, folk ideologies as well as "western style" systems for health assessment must be considered. In reality, socioeconomic factors are directly related to government policies concerning health. As Dedeoglu (1990:391) observed for those most at risk:

> These groups are people living in rural areas, especially in the eastern, northern, and middle Anatolia, and people living in the peri-urban settlements. Poverty, illiteracy, unemployment, harsh climate...poor hygienic facilities, inadequacy of health and other public services, widespread infections and parasitic diseases and undernutrition put these people's health and life at risk. Amongst them infants, pre-school children, and mothers are particularly vulnerable. Workers also are

> vulnerable, many of them working under high risks of accident and occupational disease with no job security.

Accordingly, despite it being one of the few countries in Europe to produce enough food resources to feed the entire population, undernutrition, and associated diseases such as tuberculosis are pervasive (Ibid). Aksit and Aksit (1989) found "unexpectedly high" infant mortality regionally in Turkey, despite outreach campaigns initiated by UNICEF. In the Turkish Medical Association's [TMA] (1995:30) report on health services and health personnel problems in the southeast, investigators found "the malnutrition ratio...determined as 24.1% and 85.2% of children were found to be anemic, 65.3% of whom had severe anemia" (see Kocak and Paydas 1992). Also, in general, the population studied (all centered around the city of Diyarbakir) suffers from serious degrees of protein, calcium, vitamin, E, vitamin A, and iron deficiency. The cause, according to the authors, is twofold: an influx of immigration into the area; and strife between the PKK (Kurdish Worker's Party, a radical political organization) and the Turkish military, resulting in medical personnel being included as targets for demonstrations. This resulted in reducing the number of willing participants in the public health care clinics.

Conclusion

According to Goodman and Leatherman (1998:xv), "Anthropology is at the nexus of the biological and social, a biocultural synthesis spanning an enormous range of comparative, historical and dynamic material." Given Turkey's turbulent political history, as well as an economic gap of extreme proportions, it is not surprising that one

sees numerous options for health care (all hearkening back to Kleinman's Explanatory Model), and that consequently, order of resort in some regions would be based more on access to available resources than on personal choice. Again, by examining some of the epidemiological characteristics of the region, and further, which options are available to those within certain regions, one may gain a better understanding of social, political and medical (service) inequities in operation around this population.

CHAPTER 6
RESULTS OF SHORT INTERVIEW SCHEDULES IN ÜMRANIYE

Introduction

Within this chapter the results of the short interview schedules are given and interpreted. Attitudes about religion and politics, the health care system in Turkey, folk knowledge about treatment of minor ailments, general economic status and resources, perceptions of relative deprivation, and initiative and agency of the participants are also explored. Statistical analysis of these interviews is integrated into the discussion.

The individuals who occupy the squatter settlements of Istanbul come from all over Turkey, but mainly from very poor rural areas. They grab whatever they can find to make a house, with four walls and a roof, and as the years go by, these houses are improved upon. Turkey is not set up to be a welfare state, there are no food stamps, and health care is limited as is governmental assistance. *Gecekondu* residents have to be very resourceful because 1) there is very little in the way of social services; 2) the structural development (i.e., housing and roads) is poor; and 3) public works are at a base level. The gap between socio-economic levels is very great. In Istanbul there is evidence of this poverty everywhere. There is a population of socially alienated street children. There are impoverished families in the *gecekondu*; there are elderly women who must comb the streets for handouts... and then in other parts of the city there are wealthy people marking this contrast. As an elderly woman begs on the street, an affluent teenager walks by–

invariably attached to a cell phone–with shopping bags from expensive shops. And yet the people in the *gecekondu* manage. The women I visited in these catchment areas are incredibly resourceful. They have no legitimate means of upwardly mobility, but they do so pragmatically. They arrive with nothing, but slowly build a network, slowly build their resources, and send their children to public schools with the hope that the next generation will fare a little better.

In this chapter I will explore some of the attitudes these *gecekondu* women have about religion, health, economics. All interviews were conducted with my female assistant Merve (pronounced mehr`veh). To give an idea of what was involved in conducting the 119 short interviews that form the core of this chapter, I would like to include some excerpts from my journals before getting into the results of these data:

Merve and I have started to make our rounds in Ümraniye. We continued for some weeks at the point where Kaan and I had made our initial entry, and upon exhausting resources there, moved to an adjacent neighborhood–same catchment area–but about 1/4 a mile away from the other neighborhood. By way of Ordu Sokak we started again, and managed nine interviews the first day. On some days the heat was sweltering, and on the odd day when there was a climatic reprieve, we were grateful. Today it was finally cooler, and the women were incredibly hospitable. One interview was with an older couple–both incredibly sweet. The man–approximately 70 years old–scaled his fig tree and we ate the delicious huge figs while we chatted. I was interested in their responses about the supernatural. While virtually everyone believes in *nazar* (the evil eye), not everyone believes in *cins* (genies), but this man told of an incident. His cousin was napping on the balcony one day, when suddenly he felt as if a cat jumped on him, so he "threw it off." But when he opened his eyes, no cat in sight. Suddenly his body was covered with severe burns from which he later died... And another story of a relative who would wake up screaming just after midnight every night. He was possessed and screaming and then he went to the *hoca* for *muska* (an amulet) and as long as he wore it he was fine. As soon as he took it off the fits began again. So I'm thinking that when I get to the more in depth interviews I should ask for stories since people like to tell them. I think it would be more effective than these blunt questions. One of the questions I ask people is: Have you ever been helped by a *hoca*, and people seem very uneasy when asked and invariably say "no." I think a fear of being judged as backwards is the reason. Will have to try to employ another approach. Also, get the feeling sometimes that Merve

is leading the questions. Wonder if I should have saved the questions for last.

Another day: today we hit the *gecekondu* again full force. It's amazingly hot now, and a stale southern breeze blows hard causing the dust to swirl around (invariably into my eyes). The first house we came across today looked like most others. Loose handmade brick covered liberally with smatterings of stucco..Turkish carpets strewn on the ground...a few pieces of furniture...arabesque music playing somewhere in the background. We sat at the doorstep and a youngish man (23 yrs old) came out to greet us. The only thing he had on were some rather tight shorts. He immediately squatted at our feet and began to whisper conspiratorially to Merve. What is it, I kept asking. She was blushing from head to toe, and said "I will tell you later." So we started our interview, and the man kept leering, smiling . He's odd, I thought. We finished, and as we walked away I asked Merve what that was about. "He is a...I don't know. He makes people pay for sex." He's a gigolo?? "Yes, that's it." Incidentally this young man lived with his mother and his wife (who of course knew nothing of his nocturnal activities), in one of the most conservative areas of town. I wondered how he could pull it off. I worry about Turkey. There's a lot of denial here about STDs and in particular HIV. Street prostitution is on the rise, and even though brothels are legal here, and supposedly the women must undergo routine medical exams, risk is high, and public health doctors have told me that Turkish men find "protection" unnecessary as that's a woman's concern. In five years time it could be devastating. Ok, so the next house we hit was also interesting. In August people stock up for winter. We came across a jolly house of women who were making pasta for the winter and also bread. They had huge tubs of dough, which they cut and then rolled into flat discs and cooked for a minute over a flat iron on an open fire . They were all originally from Konya (south central Turkey), and they laughed and gossiped, and continued to work, inviting us to taste the delicious bread when it was cooked (Figure 6).

Figure 6 Bread Women from Konya

Another day: I have gained something of a reputation among the *gecekondu* dwellers. Responses are of two types: 1) when they see me walking down the street with my clipboard in hand, they flee, or 2) they stand expectantly and beckon me in. So this week I decided to cover some virgin territory. We drove to another section of the catchment area [remember it is vast with some 900,000 people within], and began our infiltration of the local culture. We've been getting a lot of rain lately, so the dirt roads are thick with rust colored mud. I trekked through while Merve made grimacing faces and moans of protest. We seemed to be a fascinating source of interest right off the bat, because 1) we arrived in a car (Merve has a very nice Peugeot), and 2) we had those clipboards in hand, and 3) neither of us wore a head scarf. Today we began our queries, and immediately came across a woman scrubbing fleece bedding before winter sets in (used to stuff the beds). One good thing about Merve...she is a law student, and rather good at convincing folks to participate, even if they tell us "no" from the start. My job is to look jovial and interested...which works wonders. A variation of good cop bad cop...and it has been a successful strategy. So we sat in the first woman's yard, and began our interview. Before long about a dozen children and a dozen more grownups surrounded us. The children, I have to say, are charming. They learn bits of English at school and are eager to try it out. They are quite heterogeneous in terms of appearance...some with green eyes, some with blue..some with sandy colored hair, some quite dark. And they followed us around the whole time, pointing out houses where we might find willing participants. One good thing about the first woman was because she had agreed to do it, others were more willing. So among that first group we knocked out seven interviews.

The next house we came to looked rather derelict. However, it was very different on the inside. Beautiful Turkish kilims, an old pipe stove ...everything immaculate. The woman we spoke with had three gorgeous daughters aged 13, 15 and 17, and they all sat quietly laboring over their needlework and knitting (very elaborate and exacting patterns) as we spoke with their
mother. She answered us carefully, thinking about each question to give us a precise answer. The television (every bit as much a staple in Turkish culture as in American) was on in the background, and I noticed when a cute man was on screen the girls tittered and passed knowing glances to one another.

After our interview marathon, we walked down the road and came to another house. A young girl of 15 answered, and we asked if her mother was home, at which point she informed us that she was a "gelin" which literally means "one who comes" and is a term used for new daughter-in-laws. She declined to be interviewed because no one else was home...but I was reminded that traditional values are still very much in evidence even in Istanbul.

Next we came across an older woman sitting on a stoop doing some needlework (these women, by the way, are amazingly skilled at needlework). She was a wicked old woman with a bawdy sense of humor, but agreed to let us speak with her. She screamed down the street and a horde of people materialized and approached us (in spite of my insistence that only individuals be interviewed, it is invariably a group effort). We began...but poor Merve was harassed the whole time. She was wearing her designer

gear...designer tennis shoes, Gucci watch, lots of conspicuous jewelry (which, by the way, I had urged her to leave at home... so she was kind of asking for it). The woman would answer a question--in a circuitous way--and then slap poor Merve on the back and scream "Give me that watch!" or "Take that sweater off, I want it!" and then laugh uproariously to the general hilarity of all (except Merve). The old woman leaned over and looked at me to see if I could be tortured too, but I winked at her and she winked back, and from that point on I was OK. I wanted to interview some more folks from that group, but my beleaguered assistant looked ready to explode, so we moved on...

As the above excerpts show, interview schedules are often more informative at the informal level, when the guards are down, and much that is covered in the structured interview pales by comparison to the observations and interactions that surround them. None the less, in order to garner specific information (i.e., "facts") about household economy, health status, nutrition and the like, the questions asked during the "formal" portion of the interview provided the data necessary to fill in the picture a bit more. The following segments show the results of the above referenced short interview schedules.

Residence Patterns

The results of questions regarding residence patterns in Ümraniye show that 87.4% of respondents had relatives living in Istanbul (59.7% of these lived in Ümraniye), while 88.6% of the spouses' relatives also lived in Istanbul (4.2% of the sample were not married and this last question didn't apply to them). These results shown in Table 1 are in keeping with my general assumptions about network pull in general. (See also Appendix A.)

Table 1 Residence Patterns for *Gecekondu* Women (n=119=100%)

Question	yes	yes%	no	no%
Do you have Relatives in Istanbul ?	104	87.4	15	12.6
Do these Relatives live in Umraniye ?	71	59.7	48	40.3
Do your Husband's relatives live in Istanbul ?	101	88.6	13	11.4
Not Married (N/A)	5	4.2%		

Economy/Consumerism

One of the most striking features about the *gecekondu* women (more specifically their environs) that I noticed, was that in spite of a marked degree of poverty and economic distress in general, and in spite of being on the margins of the consumer market, most of these women possessed a number of consumer items which one might assume were beyond their means. At the beginning of this study, my focus was more on the historic and social aspects of health and belief systems, but after visiting a few of these women's homes, and seeing the various household products there, I felt compelled to itemize consumer items and amenities in order to infer which items are deemed important as part of their urban status. (See Table 2)

Table 2 Status and Consumer Items Used by the *Gecekondu* Residents (n=77=100%)*

Items/Status	Frequency	Percentage
House owner	43	55.8
Rent	34	44.2
Television	69	89.6
Radio	14	18.2
Cell phone	28	36.4
Car	18	23.4
Washing machine	67	87.0
Telephone	47	61.0
CD Player	15	19.5
Truck	1	1.3
Satellite	2	2.6
Cable	2	2.6

*This is a subset of my original sample of 119.

Another question was about livelihood, and what kinds of jobs the husbands (and in a few cases the women) had by way of employment. Figure 7 shows the responses that I got in this matter. There was quite a range in scope and specialization among these vocations. Everything from scrap iron dealer to interior decorator made the list, which shows the versatility of the inhabitants in this area, and also the personal and creative agency with which they seek a livelihood. However, it is also noted that only five of the women interviewed were formally employed. (Note: Though I only made interview rounds in the daytime, in every house I tried the women were home, so I assume there was a low rate of formal employment among the women in my sample area.) According to income reports of these women, (see Table 3 for full details), 84% of these households only bring in an average weekly income of 10-100 million Lira (exchange rate as of

- Bazaar merchant (B)
- Buffet attendant (A)
- Builder (A)
- Butcher (A)
- Car mechanic (A)
- Chef (A)
- Cigarette vender (B)
- Civil servant (A)
- Cleans and runs wards in schools (A)
- Cleans banks (A)
- Cobbler (B)
- Coffee house owner (A)
- Coffee shop assistant (f) (A)
- Driver (A)
- Electric Welder (f) (A)
- Electrician/plumber (B)
- Fisherman (B)
- Gardener (B)
- Helper (B)
- Hospital janitor (f) (A)
- Hotel worker (A)
- Housecleaner (f) (B)
- Interior decorator (B)
- Laborer (B)
- Landlord (B)
- Machine repairman (B)
- Municipality worker (A)
- Nurses aid (A)
- Retailer (A)
- Retired (N/A)
- School cook (A)
- Scrap iron dealer (B)
- Security person (A)
- Sells grilled sheep intestines (B)
- Shipper (A)
- Shipping agent (A)
- Shoemaker (f) (B)
- Tailor (B)
- Tax office (A)
- Tea server (B)
- Textile shop (A)
- Tradesman (B)
- Traveling salesman (B)
- Unemployed (N/A)
- Welder (A)
- Whitewasher (B)
- Worker in showroom (gallery) (A)
- Works for PTT (A)

Figure 7 Vocations Seen Among the Gecekondu Sample (A marks formal employment, B self-employment)

September 2002 was $1 U.S. Dollar=1,649,041.50 Turkish Lira)–which would be 480,000,000 lira a year (about $291.00) at the lower end, and 4,800,000,000 lira a year (around $2,880.00) at the high end of the income scale. The reported incomes made the presence of a number of consumer items in each home all the more puzzling to me. Prices for items like appliances, televisions, cell phones, etc. are exorbitant in Turkey; and yet, among those interviewed, 89.6% owned a television, 61.0% had a telephone; another 36.4% had cell phones.

Table 3 Weekly Income of *Gecekondu* Residents (n=119)

Range	Frequency	Percentage
No Income	9	7.6
10 – 40 Million Lira	45	37.8
50 – 100 Million Lira	55	46.2
110 – 250 Million Lira	10	8.4
Total:	119	100

Exchange Rate as of September 1, 2002 1,600,000 TL = $1.00

In an effort to discover "unclaimed" income sources, I asked respondents to describe how they supplemented income for such household and consumer goods. Overwhelmingly the response was: finance. The credit system is available to them, and just like all consumers they are able to get into the vicious cycle of acquisition and debt in order to gain access to such household items.

Reproduction

In an effort to look at household composition and economy, as well as attitudes about family planning, I asked a number of questions about children and child rearing practices. Two questions in particular yielded interesting results. The first (Table 4) shows the number of children each woman has had, while Table 4.1 shows the *ideal* number of children women consider appropriate. Of the sample, 74.5% had 3 children or fewer, while 25.5% had given birth to four or more children. However, in terms of the

Table 4 Number of Children of *Gecekondu* and Ideal Number of Children for *Gecekondu* Residents (n=119)

Number Of Children	Frequency	Percentage	Ideal Number	Frequency	Percentage
0	16	13.5	0	1	1.0
1	13	11.0	1	10	8.0
2	26	22.0	2	73	61.0
3	33	28.0	2-3	2	2.0
4	16	13.5	3	25	21.0
5	10	8.0	4	7	6.0
6	4	3.0	5	1	1.0
7	1	1.0			
Total	119	100		119	100

"ideal," number of children 61% indicated that two children would be sufficient, with only 28% desiring any more children than that. These figures correspond with those taken by the 1997 Turkish Ministry of Health population and attitude survey.

With regard to pre- and post-natal care a number of questions were asked. Of those interviewed, 59.2% gave birth in the hospital, while 40.8% of the respondents' children were born at home. Responses to questions regarding the use of a midwife

varied and were as follows: 21 women said they had used a village midwife for delivery of their baby, 10 had used a government midwife, 2 had no help at all delivering their babies, 1 had the help of a family member and 1 had the help of a neighbor (Table 5).

Table 5 Number of Children Born in Hospital or at Home for *Gecekondu* Women and Incidence of Using a Midwife.*

Births	Frequency		Percentage
Born in hospital	183		59.2
Born at home	126		40.8
		Total	100
Birth Assistance**:			
Village Midwife	21		
Government Midwife	10		
Family Member	1		
Neighbors	1		
No Help at All	2		

*Birth Frequencies Reflect Multiple Births. (total births=309)
**Informal Assistance Reflects Home Delivery and Hospital Births (n-35)

When asked if they took any special precautions during pregnancy, 63 of the women interviewed said no, 28 said they went to the doctor more or less regularly, 4 mentioned eating healthy foods, and 2 mentioned eating lots of yogurt and milk specifically. When asked about breast-feeding practices, only 7.0% reported that they did not breast feed at all, while 26.0% breast-fed up to eleven months, and 28.7% breast fed from 1-2 years. 20.9% reported breast-feeding from 2-3 years, and 3.5% said they breast fed for three years or more. The least amount of time mentioned was 3-4 days, and the longest time mentioned was 4.5 years (Table 6). When asked to state the benefits of breast-feeding, 59 women cited immunological reasons, 39 said there was nutritional

value, 7 stated that it was done for contraceptive reasons, and 5 said it was for economical reasons. Multiple answers were allowed in this section.

Table 6 Time of Breastfeeding for *Gecekondu* women and Perceived Benefits (n=115)

Time of Breastfeeding*	Frequency**	Percentage	Benefits***	Frequency
No Breastfeeding	8	7.0	Immunological	59
Less than a month	2	1.7	Nutritional	39
1 to 11 months	28	24.3	Contraceptive	7
1 to 2 years	33	28.7	Economical	5
2 to 3 years	24	20.9	No Response	7
3 years or more	4	3.5		
No Children (N/A)	16	13.9		
Total:	115	100		

*The least amount mentioned was 3-4 days, the longest 4.5 years.
**4 respondents from the total of 119 were unable to answer this question.
***Multiple responses were allowed. Column does not correspond to previous row.

Health Status

In general there were two attitudes toward questions regarding the quality of primary health care: respondents were either eager to air their grievances, or they were completely reluctant to give information and instead provided a rote "it was fine" type of response. While the author realizes a wide range of experience must exist depending on the individual and the disorder, support literature and first hand observation of both the local health clinic and state hospital leads to the conclusion that quality health care for the lower SES *gecekondu* women is not sufficient to meet their needs and expectations. In terms of private vs. state run facilities, a number of Turkish friends informed me that they would never want to be admitted to a state care facility because of the bad reputation these places have. Just examining the parking lot of the private facilities (with many

luxury cars filling the parking lot–Mercedes, Lexus, BMW...), and comparing with that of the unpaved, haphazard parking lot of the state facilities (with, of course, economy cars–probably belonging mostly to staff since the patients rarely have their own vehicle) there is a visible sign of affluence and we assume privilege.

Attitudes in relation to *ilgi* (personal attention) at the hospital varied quite a bit, though it should be noted that most respondents were more interested in giving a correct or polite response rather than one which–I suspect–reflected their true feelings and experience.

Regarding nurses, doctors and hospital facilities:

1. They were nice, I received excellent care; the hospital was reasonably clean

2. The nurses were nice, the doctors were good, I received excellent care and the hospital was reasonably clean.

3. The hospital was clean.

4. I found the staff inattentive.

5. Doctors and nurses were nice, but the hospital was somewhat unclean

6. The nurses were very careful and the doctors nice.

7. The nurses were not careful, and the doctors were bad. The medical treatment was not helpful, the hospital was reasonably clean.

8. Some nurses were nice, some weren't. The doctors were very good. I received good care, but the hospital was somewhat dirty.

9. The doctors and nurses were ok, but they were inattentive and the hospital was somewhat unclean.

10. The nurses were very bad because they ignore, they are very busy. The doctor wouldn't ever tell me what's wrong, just says take the medication and go home. My experience with the hospital was horrible. The facility itself was reasonably clean.

11. The nurses weren't very nice but the doctors were nice.

12. The nurses weren't nice but they weren't bad. The doctors were nice. But most of them are not very interested maybe because there are a lot of patients. The hospital was ok.

13. The nurses were nice, but the doctor was incompetent. The medical treatment was not helpful, and the hospital itself was dirty.

14. The nurses were rude, the doctors were nice. The staff was inattentive. The hospital was reasonably clean.

15. The care was good but the hospital was somewhat unclean.

16. The staff were helpful but the treatment was not effective.

17. The staff was somewhat inattentive and the hospital somewhat dirty.

18. ER doctors are not good but the others were nice.

19. The nurses were nice; the doctors were ok.

It should be noted that these were the only original responses out of some 119 respondents. Most chose a polite and short reply to my questions regarding quality in the hospitals. One of the most common observations in the field when attempting to discern attitudes about folk or traditional health care was a marked self-conscious self-condemnation, and denial on the parts of those who would be most likely to use this type of health care strategy.

When asked about home care, and who in the family was the primary care giver, answers were as follows: 48% of the women interviewed were the primary care givers in their homes; 37.8% said their husbands were the primary care givers (though I later found this was more due to executive decisions regarding major illness, rather than day to day small ailments and complaints); some other types of responses were reported, and are

listed in the table. Unexpected responses included the son (4.2%) and "everyone" (3.4%). (Table 7).

Table 7 Medical Problems or Diseases and Caregivers for *Gecekondu* Residents (n=119)

Ailment*	Frequency	Percentage	Care	** Frequency	Percentage
Hypertension	26	28.0	Myself	57	48.0
Diabetes	6	6.5	Husband	45	37.8
Headache	83	89.0	Son	5	4.2
Arthritis	42	45.2	Everyone	4	3.4
Liver	8	8.6	Mother	2	1.7
Kidney	12	12.9	Sister	2	1.7
Eye	16	17.2	Relatives	1	0.8
Thyroid	5	5.4	Daughter	1	0.8
Cholesterol high	9	9.7	Daughter in Law	1	0.8
Heart	9	9.7	Not Sure	1	0.8
Anemia	36	38.7			
Osteoporosis	1	1.0	Total:	119	100.00
Low Calcium	1	1.0			
No Problems	26	21.8			

*Some respondents reported multiple complaints.
**Rows do not correspond to columns.

One of the questions I asked about health care, was whether or not they had experienced any major health problems in the past (or present). I used both a listing method and open ended questions to arrive at the results. Table 7 also shows the results of the first question and frequency for these types of illnesses. The severity of the disorder is variable on this list, because I wanted to show lifestyle diseases (e.g. high cholesterol), as well as nutritionally indicated illness (anemia) and stress related ailments (hypertension and headaches). Results varied, though significantly, 89% of those questioned suffered from headaches, while the second most common complaint was arthritis. Anemia was present in 38.7% of the sample and hypertension in 28%. Additional results may be seen in the table.

One question for the *gecekondu* women attempted to determine order of resort, and utilization of over the counter medications. Did these women include the OTC medicines as part of their strategy? Overwhelmingly, when I asked if these women used pharmacy medications, the answer was "no." However, when I provided a list of common "medicine cabinet" items and asked them to tell me which of these they usually kept on hand, the results were quite different (see Table 8). The most common OTC medication kept in the home was aspirin (65.5%) followed by anti-bacterial ointment (56.3%) and then cough medicine (52.1%). A range of other products was also in use by these women, providing some evidence that they took agency upon themselves to treat minor complaints at home.

Table 8 Medical Products Kept by Gecekondu Respondents (n=119)

Product	Frequency	Percentage
Aspirin	78	65.5
Cough Medicine	62	52.1
Band – Aids	57	47.9
Anti – Bacterial Ointment	67	56.3
Throat Lozenges	18	15.1
Antiseptics	47	39.5
Eye Drops	25	21.0
Vitamins	38	31.9
Anti – Diarrheal	14	11.8
Decongestant	6	5.1
Anti – Allergy	12	11.2
Thermometer	23	21.5
Anti – Depressant	1	1.0
No Products Kept	12	10.1

A litany of ailments and disorders experienced by the *gecekondu* respondents illustrates the need for better health care treatment for this group. While many questioned spoke of

primary treatment for a given disorder, general attitudes were fatalistic, with no penchant for better care or preventative care.

Some Complaints Suffered by the *Gecekondu* Respondents:

'cardiac insufficiency'
'water in the bones'?
amenorrhea
anemia
angina
appendicitis
arthritis
brain inflammation
breast cancer
bronchitis
central nervous disorder
cerebral hemorrhage
colitis
complication with pregnancy
diabetes
ectopic pregnancy
edema
elephantitis
epilepsy

liver disease
low calcium
menopause
migraine
nervous disorders
osteoporosis
ovarian problems
paralysis (with governmental assistance)
physical deformity (hunchback)

eye problems (cataract, glaucoma)
fat in the liver
gastric disorder
gastric bleeding
goiter

headaches
heart disease
hemophilia
hernia
high cholesterol
hormonal disorders
hypertension
hypotension
ingrown hair
intestinitis
joint problems
kidney problems (kidney stone)

poisoned
reproductive problems (hysterectomy)
TB
thyroid dysfunction
tonsilitis
trauma
ulcer
unspecified stomach pain

Nutrition

A brief nutritional assessment of the *gecekondu* participants was taken during the short interview schedules in an effort to determine general vitamin, mineral and micro nutrient intake among this group. Because this data was self reported (i.e., estimated by the respondents, since urine and blood serum analyses were not possible), I inquired about common foods in the Turkish diet, and asked the women to tell me how many days a week they consumed each of the items on my list (see Tables 9 and 10). These foods include meat as a general category, with the assumption that it would most likely be lamb, beef, chicken or goat; also listed were dairy products, vegetables, grains, starches, fruit, bread, cola, coffee, tea and eggs. One limitation of the food category list is seafood, which I omitted after being told that the *gecekondu* people of Ümraniye don't eat fish, as it is a luxury item (I later realized that this was not a sound decision based merely on recommendation. It remains a short coming nonetheless). Based on the data obtained I ranked items according to the frequency of weekly consumption. To look at this ranking (Table 10) one sees right away that bread is the staple item in the diet (I would suggest that this penchant moves across social and economic lines, since the general attitude I experienced wherever I was in Turkey was "if there isn't bread with the meal, it isn't a meal.") Additionally, Turkey is a big tea-drinking nation, so it was not surprising that 116 out of 119 respondents drank copious amounts of tea on a daily basis. Other common foods (vegetables, fruit, dairy products, etc.) are consumed at the least several times a week, though it should be mentioned that milk is not a preferred beverage in Turkey, and in fact in the Middle East in general (*ayran* is more common), and 62 of the

women questioned never drank it as such. Most notably, meat consumption was very low among this group. A full 58.8% of the respondents reported that they did not consume

Table 9 Average Meat Consumption per Week for *Gecekondu* Residents (n=119)

Frequency	Frequency	Percentage
0	70	58.8
1 – 2	28	23.5
2 – 3	12	10.1
3 – 4	3	2.5
5 - >	6	5.1
Total:	119	100

meat of any description at all on a weekly basis. This figure is due to economic necessity, not vegetarianism. 23.5% consumed some form of meat 1-2 times a week; 10.1% ate meat 2-3 times a week; 2.5% ate meat 3-4 times a week; and 5.1% consumed meat five or more times a week. Other items of nutritional interest are as follows (Items are ranked by the frequency with which they are consumed on a daily basis. For specific rates per item, per day see Table 10). Also included below are common nutrients associated with these foods (highest rates only are noted, of foods with optimal vitamin potency via most beneficial preparation, after Mervyn and Chem 1984):

1. Bread	mg per 100g: thiamine (0.18), riboflavin (0.03)
2. Tea	no nutritional value
3. Cheese (feta)	mg per 100g: vitamin A (0.032), carotene (0.018)
4. Tomatoes	mg per 100g: vitamin E (1.4mg)
5. Vegetables	most notably B vitamins, except B12
6. Fruits	E and B vitamins (except B12)
7. Yogurt	B vitamins and some protein
8. Eggs	protein, moderate levels of vitamins except C
9. Potatoes	carotene, vitamin E, vitamin C
10. Leafy vegetables	variable

11. Ayran	same as yogurt
12. Milk	good source of all the vitamins; protein
13. Rice/Pasta	B vitamins
14. Cola	no nutritional value
15. Coffee	no nutritional value
16. Bulgur	not available
17. Corn (seasonal)	only traces of some B vitamins
18. Beans	protein; carotene and B vitamins
19. Sweets	variable

In relation to the nutritional intake of the *gecekondu* respondents, I calculated Body Mass Indices (BMI) for these individuals, based on self-reported heights and weights. Since I did not take these measurements myself, I assume there may be a margin of error, but the rough estimations (following the mean) are shown in Table 11. For the 20-23 year old group average BMI was 23.11; for those between 25-32 average BMI was 27.05; for those between 25-44 BMI was 25.50; for women 45-53 BMI was 26.28; and for those between the ages of 54-65 average BMI was 25.47. According to standards set by Wolf et al. (1999) most age groups fell within the normal limits for body mass index (though at the higher end of the range), with the exception of the 25-34 year olds, who exceeded the range by 2.05 points, indicating a tendency toward a slightly heavier body type. In spite of the fact that answers to the nutritional portion of the interview revealed a substandard dietary intake, the women did not appear to suffer from caloric deficiencies so much as other types of deficiencies (for example protein and certain nutrients). The bulk of the *gecekondu* diet seems to be comprised of carbohydrates, and while further investigation would be required as to the exact status of their nutritional health, malnutrition and undernutrition may be repercussions of the limited scope of nutritional intake seen among this group.

Table 10
Ranking of Foods Per Day Eaten by Gecekondu Residents (n= 119)

	1	2	3	4	5	6	7	8	9	10
No of Days per Week	Bread	Tea	Cheese	Tomato	Other Veg.	Fruit	Yoghurt	Eggs	Potato	Leafy Veg.
0	1	1	8	20	9	15	9	11	4	12
1	0	2	3	11	16	21	26	14	22	27
2	0	0	4	0	12	7	12	24	6	10
3	0	0	4	2	16	14	12	14	15	20
4	0	0	2	2	5	9	5	7	14	8
5	0	0	3	3	4	4	1	2	14	4
6	0	0	0	0	0	2	1	3	4	2
7	118	116	95	81	57	47	45	44	40	37

	11	12	13	14	15	16	17	18	19
No of Days per Week	Ayran	Milk	Rice	Cola	Coffee	Bulgur	Corn	Beans	Sweets
0	28	62	8	59	81	37	79	19	86
1	20	9	30	32	23	29	29	64	20
2	10	6	35	5	5	18	5	27	6
3	8	9	23	4	2	10	1	1	4
4	13	5	6	5	0	5	2	1	1
5	3	2	1	2	0	3	0	1	1
6	2	0	1	0	0	2	0	0	0
7	35	26	15	10	8	5	3	1	1

Table 11 Body Mass Indices of *Gecekondu* Residents (n=117)*

Age Range of Respondents	BMI Range**	Average BMI
20 – 23 (n=12)	21.10 – 26.30	23.11
25 – 34 (n=37)	15.57 – 42.97	27.05
35 – 44 (n=42)	15.63 – 36.73	25.60
45 – 53 (n=18)	16.00 – 41.62	26.28
54 – 65 (n=8)	16.00 – 38.06	25.47

*One 17 year old and one 80 year old were eliminated based on age.
**According to Wolf et al. 1999

Attitudes about Living in Istanbul

In an effort to understand the degree to which residents of Ümraniye have become integrated into the city, and how they have adapted psychologically, I asked a number of open-ended questions about their attitudes about living in Istanbul. I also asked about some of the things they missed from their natal village (and conversely which things were "better" in Istanbul). Responses to these questions are shown in Table 12. Results are as follows: 45.4% of those questioned liked being in Istanbul, 28.6% said they didn't like living in Istanbul; 21.0% "kind of" liked living there; 3.4% mentioned that they didn't have a choice in the matter and were non-committal; 0.8% said they love living in Istanbul, and 0.8% mentioned that in any case it was better than living in the village.

When asked what they missed most from the natal village responses varied. The most common answer was "the village" itself; many said "good air and water," which is rather telling considering the poor state of public works in the *gecekondu*. Many missed

family and parents, again a telling point, which would indicate a break in family network associations for the 12.5% (Table 1) who did not have family in Istanbul. Twenty-six women didn't miss a thing about their natal village, indicating a higher degree of adaptation (or more stressful living circumstances back home). A few individuals missed things like trees, nature, and the animals; and this probably indicates dissatisfaction with the fast, dirty pace of city life compared to that of the village. Incidentally, Istanbul is nearly devoid of trees, due to centuries of growth, expansion and industry, except for those existing in the public parks. When the women were asked to name some of the things that are better about Istanbul, nearly half of those questioned said "nothing!" Individual responses indicated a range of other benefits, namely, life status, education, health opportunities (significantly), work opportunities, better future for the kids, better living conditions, and also "the family is here and that's better." It was also noted that while a respondent might answer "yes" when asked if she liked living in Istanbul, she might answer something like "everything" when asked what she missed about her natal village. Answers to the quality of life questions may be seen in Table 12 below.

Table 12. Range of Attitudes about Gecekondu Respondents' Adjustment/Satisfaction in Living in Istanbul

A) Do you like living in Istanbul?	Frequency	%	*B) What do you miss from home?	Frequency	*C) Benefits of Istanbul	Frequency
I like it here.	54	45.4	The Village Itself	34	Nothing	58
I don't like to be here.	34	28.6	Nothing	26	Education	9
I kind of like being here.	25	21.0	Everything	18	Work Opportunities	8
I have to be here.	4	3.4	Good Air and Water	15	Better Social Status	7
It's better than the village.	1	0.8	My Parents	11	Better Life Status	5
I love it here.	1	0.8	My Relatives	8	Money	5
			My Family	7	Health Opportunities	4
			I can't Remember	5	Comfort	4
			The Trees/Green	1	No Answer	4
			The Animals	1	Family is Here	2
			No Answer	1	It's Just Better	2
					Everything	2
					More Work	
					The Old Istanbul was Better	1
					Nice People	1
					Modern City	1
					Better Future for Kids	1
					Living Conditions	1
					Nowhere is Good	1
					Travelling is Easy	1
					I Love Istanbul	1
					Better than Before	1
					It is More Clean	1
					House and Family	1

*Multiple responses were often given for items B and C.

Education

In trying to determine the relationship between educational level and health status, I asked the *gecekondu* respondents several questions having to do with attitudes toward education, and personal level of education. Results of these questions show that among 57.1% of the sample, education was fairly important (Table 13), while for 2.5% it was extremely important; 6.1% felt that it was important for boys; 2.5% said it was important for girls to be educated; and 29.4% said both girls and boys should be educated. Of the three women who felt that a girl's education was more important, each woman also commented on Turkey being a "man's world," and women needing an education in order to break free from traditional roles in order to achieve something better. One woman told me that she wanted her daughters to be as self-sufficient as possible, and not to have to rely on a husband, as she did. The other two women told me that women had a lot of catching up to do in order to compete. All expressed a desire for their daughters to achieve more than they had, and to find meaning in their chosen vocations. In terms of the women's own educational level, 29% had no formal education, 57% had been to elementary school, 7% had been to middle school, 7% had been to high school, and only 1% to college (Table 13). While an elementary education may have been sufficient for the majority of these women in their natal towns and villages, moving to a city such as Istanbul no doubt heightened awareness about a lack of economic opportunity for those without the necessary skills and education. Furthermore, by exposure to different social sectors, attitudes about relative deprivation, integration of diverse social groups and values must have to be revised, not remain in enclave isolation.

Table 13 The Importance of Education to *Gecekondu* Residents and Educational Background of Respondents (n=119)

Level of Importance	**Frequency**	**Percentage**
Extremely important	3	2.5
Somewhat important	68	57.1
Not very important	0	0
Important for boys	7	6.1
Important for girls	3	2.5
Important for boys and girls	35	29.4
Unsure	1	0.8
No Opinion	2	1.6
Total	119	100
Level of Education Of Respondents		
None	35	29
Elementary School	68	57
Middle School	7	6
High School	8	7
College	1	1
University	0	0
Total	119	100

Conclusion

Results of the short interview schedules indicate a heightened awareness on the parts of the *gecekondu* women about social station, material desire, economic dependency, and upward mobility. Most of the women I interviewed spoke with a kind

of fatalism that was not borne of ignorance, but rather frustration—frustration that the resources were inadequate, frustration with the Turkish government, frustration with the medical system. But these attitudes were only discernable between the lines. The public face these women put on was one of dedicated "correctness." Many of the correct answers were stated in a stoic and almost "just so" manner when direct questions were asked, and the more subtle truth emerged only when conversation strayed from the formality of those interview questions to more open ended conversations about life decisions and strategies. In chapters 7, 8 and 9 some more results garnered from the short interview schedules are placed in the context of the subjects explored in these chapters.

CHAPTER 7
ETHNOPHARMACOLOGY

Introduction

Ethnopharmacology is the study of the physical properties of indigenous remedies, and how medicinal materials are interpreted (Sargent and Johnson 1996). Of particular interest to the ethnopharmacologist is whether the compositions used are efficacious for treatment, and further how knowledge is transmitted culturally. Also of interest is whether or not a particular medicine is widely used and commonly interpreted cross-culturally. Since plant therapy is often used in combination with spiritual therapeutics and other socially valued treatments, the use of local medicines in cultural context is of supreme interest to those interested in traditional healing practices. Though increasingly biomedicine in its clinical "western" incarnation is a pervasive medical paradigm, most societies utilize other types of medical resources available to them at some point, depending on the circumstances of the group—particularly if that group is at the socio-economic fringe of that social system. Of revivals in folk healing, du Toit (1998) notes: "Aging and poverty create favorable conditions for people to turn to the tried and tested, aspects of healing retrieved from their cultural reservoir." Honda et al (1996), in studying traditional medicine in western Turkey found that "In spite of the accessibility of Western medicine, many people in the studied part of West Anatolia still continue to depend, at least for the treatment of some simple diseases, on herbal

remedies." Du Toit (1997 notes that two medical paradigms collide (i.e., the biomedical model and the traditional model), when disadvantaged groups are faced with an encapsulating system of health care that excludes them; therefore, the former must fall back on a culturally significant (and accessible) healing regimen to combat illness. In trying to understand, and at times negotiate intervention between medical systems, the ethnopharmacologist must be able to understand both worlds and act as guide and mediator.

Another "crossover" area is the pharmacy, and self-treatment and interpretation of pharmaceuticals. In Turkey drugs and other products certified by the medical establishment, and for the most part considered safe (though their FDA [TTB]) standards are arguably more lax than those seen in the USA), can be easily obtained by the public, and used to treat minor ailments. While there are some areas where this is not a good idea (such as the case of antibiotics, which are often dispensed without a prescription), the pharmacist often serves as a kind of informal consultant, bridging the medical and popular sectors.

Herbalists constitute another category in the medically pluralistic Turkish system. They can be seen at the street markets and spice bazaars, selling fresh produce, herbs and other products with medicinal value. While their opinions are valued, it is often up to the woman (as is usually the case) to be versed in the uses of such products. This falls into the popular sector and home remedy, for which there is a corresponding sector in the United States–probably most conspicuously at the ubiquitous health food market. While

the clerks and cashiers are expected to have some knowledge of the products, a great deal depends on experimentation or word of mouth.

Encounters at the Misir Carsisi

The Misir Carsisi (also known as the Egyptian Bazaar, and alternatively the Spice Bazaar) is a mini covered bazaar located in the heart of Istanbul. It is host to dozens of shops, of various descriptions—selling everything from tourist trinkets to spices and folk remedies. This bazaar was constructed in the mid-17th century, and is closely associated with the beautiful Yeni Cami mosque that stands adjacent to it. Here one may find henna to stain the hair and other body parts, as well as spices of all types, and of course various jellies, herbs and tonics for medicinal use (Figures 8 and 9). It is one of the more obvious centers for folk remedies as I discovered upon arrival in Istanbul, and given the public nature of the place, it was logical to speak with some of the shop owners at the bazaar as a starting point for my explorations in ethnopharmacology. The shop proprietors are quite used to tourists, and therefore rather outgoing salesmen. They chant to passersby to tempt a sale, and they are amazingly adept at guessing an individual's nationality, and greeting him in his native tongue after no more than a cursory glance. If they fail to get your attention, jovial greetings may take a quick turn to dramatic insult. It was a different experience for me when I went to these shops as a researcher. These outgoing men became almost shy, almost suspicious, and uncharacteristically non-vocal when pressed about their wares from an investigative perspective. The biggest obstacle I faced when introducing myself (and my desire to find out a little more about folk remedy), was

the perceived stigma associated with folk medicine. This is largely fostered by negative media coverage. With the help of my research assistant Kaan, I was ultimately able to break the communication barrier and get one of these men to open up to me.

The first shop I entered was owned by Selim, a 45-year-old Turkish man. He told me that he had been in the business for quite a few years, and that he had served as an apprentice for his uncle before taking over the business. When I asked him about his education in herbal medicine (secretly hoping it was linked to traditional Turkish knowledge of folk remedy), I was told that he had studied in Germany at a school for alternative healing practices (this in conjunction with his apprenticeship with his uncle back in Istanbul). His attitude toward Turkish healing practices was that they were borne of ignorance, and that eastern healing practices (i.e., Chinese herbal therapeutics) were better established, better organized, more consistent, and more reputable in general. Though Selim was generally reticent in matters of traditional therapies, he did offer a number of recipes for basic ailments (see below). When asked about the people he serviced, I was told that around half the clients were men and the other half women, with no discernable leanings based on gender. Additionally, they came from all walks of life—from foreign tourists, to middle class Turks, to those living in the poorer sections of Istanbul (i.e., the *gecekondu*). When I asked him about the most common complaints among his customers, he cited high cholesterol, diabetes, the flu, and stomach problems as the most common complaints. Listed below are some of his herbal recommendations for these ailments:

Figure 8 Front of Herbal Shop at Misir Carsisi

Figure 9 Detail of Herbal Shop

Complaint/Symptom	Treatment
Common Cold (to be mixed together and taken at once):	clover, sage, ginger, juniper, cardoon, linden tree bark.
Stomach Pain:	strong olive oil, sugar
Diabetes:	bitter almond, thyme, wormwood, okra, roasted chickpeas.

Interview with a Kadikoy Herbalist

In Kadikoy (close to Ümraniye but a more affluent area), I found an herbalist with a gorgeous little shop, where he made cosmetics, tonics, and treatments of various kinds for his patrons (Figure 10).

Figure 10 Lokman Hekim

I asked him to tell me a little about his background, the type of clientele he serviced, and also some remedies for some common ailments. The following is a translation of the interview:

I own this store and it has been eleven years. My uncles used to run this store. By that time I was in Germany and I was having other jobs there. I didn't know anything about the herbals. I came here three years ago. But I've learned. I have read all the books about it. There are a lot of books about it. Our customers are mostly very educated people, so we have to know a lot. They look at us as a half doctor (*Lokman Hekim*).

I think people should use the herbals with the chemical medicines. They are more effective together. For example, for heartburn you should use the medicine Farmodin, and beside that the herbals centaury and fennel. Then it will be more effective. People usually come to us when the medicines don't work. We had a customer who has been to a lot of doctors for stomach acid. She used a lot of medicines, but they didn't work. We advised her to use ginger and hazamber kökü. She came back one week later. She was so surprised. She said that she felt herself very ignorant for not knowing these things. She bought one of the books about it Our customers always come back and tell us if it worked or did not. There are a lot of people who have serious illnesses and they want to try the herbals as the last chance.

I only got my information [knowledge] from the books. I don't get into contact with the other herbalists. I don't think there are a lot of herbalists, who know a lot but act as if they do. For example, on the TV programs they talk like they know better than the medical doctors. I think this is very wrong. I think they should help each other. They should not stand against each other. And those kind of herbalists give the wrong information to the customers and this may cause dangerous results. For example they tell the customer to boil the herbal, which shouldn't be boiled. And I think they should read more books and learn it better. There are a lot of books on the market. There's a woman who lives in Germany named Maria Threben. Her books are really good. These books are in demand.

I have a Chinese doctor (professor) as a customer. He buys herbals for his sickness (atkuyrugu, nettle, corn, tassle, sinirli ot, centaury). His illness was nephritis.

My customers are mostly women, but from all ages. They don't come by accident. They come by knowing. My customers are mostly from the upper socio-economy class but there are also some from the middle class. I don't like advertising. For me the biggest advertisement is the trust. But I have some famous customers, they do advertise me and my store during their interviews. I'll tell you some experiences with my customers:

1. I had a friend who always said that he doesn't believe in herbals. Unfortunately later

he learned that he had stomach cancer. He went to the doctor. The doctor prescribed some medications and told him to come back after one month. During this one month he came to me and said that he also wanted to use the herbals. (Calendula, ginger, hazamber kökü.) I've told him how to use the herbals. He said "I do trust you." I said "Don't trust me, trust the herbals." Then he left. After one month he went to the doctor and there was an obvious recovery. As U said before, when we use the herbals with the medicines, the recovery will be better.

2. A woman came to my store. She was forty years old. She had intestine cancer. I've told her to use these herbals: nettle, calendula, yarrow, Swedish syrup, and at kuyrugu. She used it for four weeks. The first week her constipation problems became less. At the end of four weeks she had recovered.
I can also tell you some recipes for common illnesses:

Flu and cold	====>	Gargling with sage. Also linden tree tea with aspirin.
Migraine	====>	Swedish syrup, broad cloth flower.
Eczema	====>	Nettle, tamarind, chicory.
Fatigue	====>	Ginseng
Diarrhea	====>	Sage, yellow centaury.
Constipation	====>	Nettle, chamomile, the seed of linen

I've never had a customer who has HIV or asked for help about HIV. Also I have never received any negative pressure from the government. Thank you for the interview.

Some Folk Uses of Plant Therapy

During my interviews with the women of the Ümraniye *gecekondu*, I learned of a number of other plant therapies used to treat illness (see Table 14 for details). While many different plants were cited (e.g., *senna* for constipation, mallow and garlic as general cure-alls, thyme to increase appetite) the most common responses were for nettle (for cancer) and linden tree bark (for the stomach and flu).

Table 14 Helpful Plants for Treating Illness: Recommendations by *Gecekondu* Women

Helpful Herbs	Helpful Foods	Family Recipes
Wart Leaf (1) General	Carrots (1) Eyes	Coffee and Lemon: Headache
Mistletoe (1) Rash	Orange (5) Flu	Milk and Honey: Sore Throat
Chamomile (1) Stomach	Spinach (1) General	Water and Sugar: Stomach
Thyme (3) Appetizing	Pomegranates (1) Diarrhea	Mistletoe Wrap: Rash
Nettle (25) Cancer	Apricot (1) Diarrhea	Nettle: General
Sea Weed (1) Cough	Fruits (5) Vitamin C	Garlic: Tension
Peppermint (3) Flu	Onion (1) Eyes	Peppermint Wrap: Headache
Linden Tree (7) Flu	Peaches (1) General	Potato Mash Wrap: Headache
Papaya (2) Hair	Tea (1) Everything	Mother's Milk: Earache
Garlic (2) General	Vegetables (5) General	Eggplant Wrap: Skin
Mallow (1)	Honey (1) Cough/General	Linden Wrap: Inflammation
Collard (1) Inflammation	Liquid Food (1) General	Warm Olive Oil: Earache
Bay leaf (1) Bronchitis	Lemon (2)	Honey and Butter: Asthma
Senna (1) Constipation	Yogurt (1) General	Peppermint & Lemon:
Garden Sage (1) Cough	Butter (1) Stomach	Constipation
Parsley (1) Anemia	Sugar (1) Cough	
	No Heavy Food (1)	
	Ayran (1) General	

When asked if there were any special foods one should eat to prevent or treat illness, again, a number of foods were mentioned, but oranges (for flu) and fruits and vegetables were the most common answers. Some other interesting responses were: *ayran* for general good health, pomegranates for diarrhea, onions for eye troubles, and garden sage for a cough. When asked if they had ever received recipes from a parent, grandmother or friends, those questioned had some recommendations: Coffee and lemon can be used for headache; milk and honey for sore throat; peppermint wrap can be used for a headache; mother's milk in a baby's ear will cure an ear ache; an eggplant wrap is good for poisoning to the skin; warm olive oil is good for ear pain; honey and butter are

good for asthma; mistletoe wrap is good for rashes (other recommendations are shown in Table 14).

Conclusion

In all, very few people from the *gecekondu* admitted to knowing much about herbal remedy; whether this is the real situation or not would require further investigation. However, it does seem that there are some common treatments, perhaps falling into the "old wife's tale" category that seem to be in the public consciousness (e.g., linden tree bark for colds, and nettle for cancer and other serious ailments). After visiting the shop in Kadikoy, I was reminded of various health food stores and alternative healing shops one sees in the U.S. that fall into the "new age" healing category—a last resort for many with serious ailments, and a sector that falls near the fringe of society.

CHAPTER 8
RELIGION AND HEALTH: ISLAM IN TURKEY

Introduction

Though Turkey is officially a secular republic, Islam is still very much a part of its culture and an inseparable part of its cultural heritage. As such, religious personnel are still revered, and provide some comfort to those for whom illness is laden with religious symbolism: e.g., the evil eye (*nazar*), which is often blamed for illness and misfortune. A patient may seek the expertise of one well versed in the Quran, who then utters Quranic verse over the afflicted person, or may inscribe a prayer or holy name onto a *muska* (amulet) to ward off evil or else attract the sympathetic attention of Allah. Therefore, while politically a secular country, Turkey's religious traditions and values find a way of expression.

Domains of Healing: Socio-Linguistic Dimension

Of additional interest in this study are problems arising from different languages of distress, including categorically different diagnostic terms, personnel labels, and names and types of *materia medica*. In the present study, a major conflict occurred when one system became encapsulated by another, without a two way understanding of the conflicting languages of distress. The focus here is specifically on domains of thought, especially with regard to written, spoken and sacred/silent appeals to the supernatural (as

a function of lexical semantics). The Turkish explanatory model (for illness) sheds some light on related cognitive and linguistic processes (after Sachs 1983).

Among Turkish women there is a shared cognition about illness and its causes: there are mediated and unmediated forces against which one must act and prepare (Sachs 1983). There are two classes of mediated forces–both of which result in misfortune and illness: there is intentional evil brought on by the magic (*buyu*, of which there is positive and negative) and sorcery of humans or demons (*cin*s), and there is unintentional evil, such as that produced by the evil eye. For the latter, admiration and envy (even a simple statement such as "what a beautiful child!") are enough to cast misfortune on the object of one's admiration. This inadvertent force is known as *nazar*–an entity inherent in the will of God. Unmediated forces are those that cause illness but are not the result of some malign human or supernatural agent. This category includes natural conditions such as heat, cold, moisture, wind, sunlight, etc. (Ibid). The women realize that such forces are a part of nature, but they still blame mediated forces when a person falls ill as a result of the cold or heat. Among central Anatolian women there is a belief that there are no accidents (Ibid). Everything happens for a reason. For example: If a boy runs down a staircase, missteps and falls, some force must have been responsible. It is this logic that enables the women to control the world in which they live–to account for misfortune. Sachs (1983) noted a particularly common attitude among Kulu women was "why me, why now?" By creating an explanatory model–comprised of beliefs about magic and its recipes, prayer, written word (from the Quran, though magic is expressly forbidden in

orthodox Islam), incantations and the power of unspoken, but strongly emoted thoughts–Kulu women gained control over their environment.

Mediated Forces

Certain categories of malign and benign agent (*melek* [angels], *peri* [feys], *cin*s [minor demons]) are recognized by the Kulu women, and credited with everything from mischievous non-threatening behavior to dire illness. *Cin*s (singular *cin*, pronounced /jin/, from the Arabic /jini/) are nocturnal spirits who live in the community. There are two types of *cin*: the harmless and the harmful varieties. The harmless variety remains harmless unless aggravated, at which time it might strike or kill a person (Sachs 1983). This *cin* masquerades in various disguises such as a black cat, lamb, eagle, giant, beautiful woman, or daughter-in-law[!] (gelin). Like the gnomes and elves of western mythology, these *cin*s afflict their victims in arbitrary ways, and are blamed for any number of misfortunes–from a woman's fainting spell to a headache. The bad *cin* causes terror , paralysis and death. Again, it is a nocturnal creature, and afflicts mostly women. A particularly feared incarnation of this spirit is the albasmasi (translated as "raid of red", and also traced to alkadin [kadin=woman]) or "woman in red" which causes a woman to see red, get hot and have cramps and choking spells. This is all associated with childbirth, and consequently there is a strict forty-day period (lohusa) after birth when the woman is most susceptible to the force and must conform to social constraints (such as staying indoors, sleeping with the lights on, never being alone).

Another feared class of supernatural agent is the alkarisi, which is a witch characterized by long hair and nails, big breasts and red apparel (Sachs 1983). She is active at twilight. She also causes illness during the lohusa period after childbirth. The new mother takes a number of precautions to thwart alkarisi, such as ritual baths, never sleeping alone or going outdoors, sleeping with sharp objects such as scissors or needles nearby (alkarisi dread sharp objects).

The only inadvertent mediated force is the *nazar*, or evil eye. Though this phenomenon is not referenced in the Quran, a passage of text is quoted (mostly by women) when a threat seems likely (after Sachs 1983):

> In the name of God the Merciful, the compassionate
> Say: I take refuge with the Lord of the Daybreak
> from the evil of what he has created,
> from the evil of darkness when it gathers,
> from the evil of women who blow on knows,
> from the evil of an envier when he envies
> -Sura CXIII]

The threat seems particularly likely when foreigners (particularly blue-eyed blond individuals–hence use of an amulet called *nazar*... made of blue glass) are around. In order to combat *nazar*, a number of preventative and curative prescriptions are known: *tuz patlama* (burn salt), *kursun dokme* (pour molten tin into cold water), *tutsuleme* (inhale smoke), *kirklama* (ritual bath during *lohusa*), *su icirme* (give water to drink), *su dokme* (pour water) are all various ways to thwart evil.

Explanations of Buyu

When *cin*s and *nazar* strike and common deterrents and precautions do not provide relief, another route to prevention, treatment and explanation of misfortune is magic or *buyu* (ibid). There are two categories of *buyu*, positive magic and negative magic. Most often *buyu* is blamed when relationships between husband and wife, mothers-in-law and daughters-in-law among others turn sour (ibid). If a man is unfaithful, a woman might turn to a *hoca* for a recipe to win him back. Usually, at both ends of the spectrum (positive and negative) enchanted *muska* (from the Greek for "something is written") are used. These *muska* can be amulets inscribed with passages from the Quran, or may be simple object such as a cube of sugar to be used in an unfaithful husband's tea, but with special "positive magic" instilled in it by a *hoca* by way of incantation and prayer. In summary, negative buyu is the result of evil intent and social transgression, while positive buyu is the act of negating a powerful negative influence. The positive magic can take the form of written or spoken prayers, images, personal objects and an expression of one's motive (love or illness).

In analyzing distinctions between objective (biological) and subjective (cultural) explanations for disease (as seen among Cameroon villagers), Pool (1994:263) defers to Geertz's view of the preferred anthropological stance when viewing groups that dichotomize in language their concepts of the world:

> The thing to ask about a burlesqued wink or a mock sheep raid [or illness or witchcraft] is not what their ontological status is. The thing to ask is what their importance is: what it is...that in their occurrence and through their agency is getting said.

The above-mediated forces–*cin*s, *buyu, albasmasi,* and *nazar*–all work within the Turkish

folk explanatory model for illness. Since illness and social disintegration are the most feared occurrences, an understanding, and even manipulation of those elements–through language–facilitates a rational life strategy. Further to this rationale, H. Vaihinger (see Bandler and Grinder 1975) wrote: "It must be remembered that the object of the world of ideas as a whole is not the portrayal of reality–this would be an utterly impossible task–but rather to provide us with an instrument for finding our way about more easily in the world" Investigation into the Turkish folk classification system of health and illness revealed the logic behind these local ideas. By examining this folk healing system, clues to underlying cognitive processes were seen in diagnostic measures, theories about pathology, theories of etiology, diagnostic and curative rituals and associated specialists. Each class of affliction (be it the result of *cin*, albasmasi, *nazar*, etc) under the domain of illness, sheds some light of those cognitive processes related to language and culture within this group..

By transforming various classes of illness or social malaise into labels connected to non-human agents, those afflicted (as well as those in the immediate family) were not assigned blame. By using sacred text (Quran) and prayer–the language of the pious–this system succeeded in dichotomizing the language to include on the one hand all that is nonhuman, mute and foreboding, and on the other all that is verbal and human yet capable of mediating earthly and spiritual forces. A number of binary oppositions and juxtapositions are included in the illustrated domain, namely mediated vs. unmediated; natural vs. supernatural; intentional vs. unintentional; positive vs. negative. The strong

imagery and belief in the power of words hints at a positive symbiosis of beliefs and language.

Kronenfeld (1996:176) states:

> Folk definitions typically are not created to convey abstract, existential truth but to communicate useful definitional information in the kinds of situations in which such information typically is needed but not present (in the minds of those involved). Our understanding of the import of folk definitions depends on our understanding of why and how they are created and used.

In the case of the Turkish Kulu women, those boundaries and definitions are explicitly stated. The protocol for dealing with evil forces is clear, and the language of distress understood by all participants.

Lexical Domain and Classification System for Folk Beliefs about Illness among Turks:

ILLNESS

Mediated Forces (Supernatural)		Unmediated Forces (Natural)
		wind sun heat cold snow rain
Intentional	Unintentional: *Nazar*	
Buyu	*Cin*s	
	Alkarisi	
Positive	Negative: Muska	
Muska Prayers Amulets Quran Incantation		

Statements about Personal Experience with the Supernatural

In terms of attitudes about the supernatural, in relation to health and well being, the sample interviewed was fairly divided when it came to belief in the supernatural. While most admitted to a general belief in *nazar*, other forms of the supernatural were either completely discounted, or found expression in a variety of experiences. Many of the women with whom I spoke believed in *cins* (genies), and a great many perpetuated this belief based on hearsay. Many also told personal stories, which illustrated how *cins* could wreak havoc and even do serious harm to an individual. Interestingly, the most insidious type of *cin* seemed to attack men, while others were of a more mischievous bent. The following excerpts were taken from these talks about the supernatural:

1. My sister was *zihinsel ozurlu* (mentally handicapped). The *hoca* said that she's married with *cins*.

2. There was a house in my village. It was full of *cins*. These *cins* throw stones to everyone who gets in the house.

3. My husband comes home from work very tired. I pray and he feels better (*Fatina suresitihlas suresi* [first chapter of the Quran])

4. I took my son to my friend's house. He played there. Next day he had difficulty walking. I prayed and then he got better.

5. One of my kids died because of *nazar*.

6. If someone says that for example one of my kids is very cute, then that kid gets sick from *nazar*.

7. Praying is very important. At night if you don't pray the *cins* will come.

8. If I feel very tired and cold, I know I have *nazar*. When I pray it goes away.

9. I had a neighbor who told all the time that the son eats too much then the boy started not eating at all.

10. I feel very tired all the time, I feel sick, then I pray and it goes away.

11. There are people who get insane because of *cin*, as I heard it.

12. I've never heard or experienced but I still do believe.

13. I heard that a woman saw something dark in the house. It was a *cin*!

14. When I was sleeping a *cin* came and slapped me, so we prayed.

15. People can be sick because of *nazar*. I didn't experience but I've heard.

16. When you step on ash you get sick. There are *cin*s in ash.

17. When I have *nazar* I feel tired all the time.

18. A neighbor's baby was sick all the time because of *nazar*. They prayed so it's getting better.

19. If I have *nazar* my work isn't going well (it's effects are psychological)

20. There was a neighbor. Whenever she comes to this house, the baby gets sick (*nazar*)

21. When I was a little kid, an old woman saw me and said that I am very cute. In half an hour a very strong headache started. So my mom prayed and then it is gone.

22. My kids have amulets on their dresses so they will be protected. From *nazar* they feel bad and tired all the time.

23. When the men pee, if the urine comes around, it causes pain in the other life.

24. My daughter had very long and beautiful hair. Everyone was saying that, but now it's shorter and not so full and beautiful (*nazar*).

25. My mom was very sick, she had *cin*s inside. Then *hoca* prayed for her so she got better.

26. My brother was sleeping in the balcony. He was sleeping. He thought that there was cat on him. He threw it but it wasn't a cat. He burned on his body and then died the next day.

27. There was a neighbor who came to visit. She said that the garderobe was very nice and it fell down.

28. When we were sitting with my friends in the garden, suddenly a building appeared. That was because of *cins*. There were people lying under the ground (spirits). [note: this is probably an extreme attitude. The man interviewed was a male prostitute and given to a rather extreme lifestyle. Also he was baiting the researcher a bit.]

29. When I was a little kid, I had a nightmare. I saw this dream till my middle age. Then someone prayed for me and it is gone.

30. One of my relatives was possessed by *cins*. So she didn't grow. She is still small.

31. When I feel very bad, someone prays for me. Then I feel better.

32. I have never experienced (*nazar*) but I have heard.

33. I have never experienced, but always praying will be good (ayet-el kursi [verse in the Quran]).

34. Sometimes my kids get sick. When I pray they get better.

35. My brother has died because of *nazar*. He was very healthy but he died suddenly.

36. When my kids get sick I'll go to my father and he prays. Then they'll get better.

37. When I get sick I go to the *hoca*.

38. I feel very tired when I am in *nazar*

Nearly all of the respondents believed in *nazar*, and in all, 42.9% of the respondents believed in a supernatural presence in general (Table 15). *Nazar* was mentioned 48 times, *cins* were mentioned 18 times, and *peri* were mentioned 6 times.

Table 15 Belief in a Supernatural Presence (n=119)

Type of Believe	Frequency	Percentage
Believes	51	42.9
Doesn't believe	62	52.1
No answer	6	5.0
Total:	119	100

Hoca

For months I attempted to find an authentic *hoca*, and for months I came up empty handed. Then, one-day fortune smiled favorably upon me during my short interview schedules and I found what I was looking for. The following excerpt from my field notes illustrates an interaction my assistant Merve and I had with the neighborhood *hoca* in Ümraniye:

Merve and I actually found a specific Ümraniye resident I wanted to find. The woman--Sucran--was quite stunned that I had a) found the place again and b) kept my promise and returned to chat with her. She invited us in to her living room and we all sat on the low divan. Sucran is a devout Muslim, and her first order of business was to educate us about our attire. I had worn some khaki pants and a short-sleeved shirt. Merve was wearing black pants and a long sleeved shirt. Neither of us wore make-up (though Merve did have painted nails...more on this later). Sucran began to lecture in an animated way, and I noticed that Merve looked completely offended but said very little in response. I could tell from the gestures that Sucran was talking about my naked forearms. Though I understand a great deal more than I used to in Turkish, Sucran's eastern accent was beyond me, so I asked Merve to translate. She blushed and seemed embarrassed. She told me that Sucran was using some rather colorful language to describe how a woman's naked forearms could and would cause men folk to be so suffused with lust that they would be unable to control their passion. (I had wondered why she kept gesturing first to her arms and then to her crotch.) She then went on—by way of allegory, I guess—to describe a horrible woman who was always at the Wednesday market wearing a short skirt, which Sucran guessed was her way of inviting all the men of Istanbul to bed with her. She tsk-tsked and said a few prayers under her breath. She then moved on to the topic of headscarves. She wondered how we could be so ignorant about this basic female accouterment. At this point two women arrived, greeted Sucran and sat on another couch opposite us. I assumed they were relatives, but they didn't say anything.

In the meantime we agreed with Sucran, and told her god-willing we would be able to change our sinful ways. This made her happy. We took out the interview questions and asked her if she wanted to participate in the study. This took quite a while to explain because she couldn't quite grasp why I would want to spend my time walking through poor areas of town asking obtuse questions that had obvious answers. Finally she agreed to do it. But then I had to explain the consent form. The problem with the consent form is that these words aren't necessarily meaningful to the person you're trying to explain them to. Instead of honing in on words like "anonymous" and "confidential" and "protection," words like "signature" are of supreme interest. Turkey is a highly bureaucratic country, and for every transaction there is a lengthy form to be filled out,

signed, stamped, filed, etc. So of course folks like to know what it is they're signing. We never did get Sucran's written consent (the *gecekondu* women won't sign anything), but she did give verbal consent, and told us we could indicate that on the form. After the informed consent issue had been settled, we began the interview. Every answer provoked a lengthy response from Sucran (including questions like: what is your age?). Then about halfway through the session, Sucran's husband came home. As he approached the door there was general mayhem. The women scattered frantically to secure their head scarves, and Sucran whispered "Put it away...Put it away!!" (meaning the questions and clipboards). Once a respectable level of decorum had been restored, the man entered, took one look at Merve and me, and walked away. Everyone sat in anxious silence. Sucran disappeared into a back room to make some tea and lunch for her husband, and Merve and I waited on the sofa watching as the chickens strutted into the living room and pecked lazily at the carpet. Finally, Sucran and her spouse re-emerged. The spouse took one look at poor Merve's red fingernail polish and began to reprimand her severely. To illustrate how truly depraved application of this cosmetic was, he pointed at my polishless nails and hissed "even she doesn't wear polish, and she's American!" thus driving the point home. To Merve's credit she nodded, and mumbled something about removing it later that evening. A good five minutes of mumbling and prayers followed as he shook his head and tsk-tsked the sorry sight of these two sinners.

Presently, the reason for the other women's visit came to light. They were there to see Sucran's husband, who was a *hoca* of some note. A *hoca* is a religious healer. He reads holy scripture over the afflicted believer, then says a prayer over a glass of water, which she (usually she) then drinks, thus spreading the word, as it were, through her body and healing her. *Hoca* and the women kneeled on the floor as Sucran continued to lecture us about the evils of men... the chickens continued their explorations, music played, children screamed...in short general pandemonium occurred as this sacred act was performed. *Hoca* then walked into another room (one presumes a bathroom) and began to vomit violently. Alarmingly. Extensively. Merve and I looked at each other in alarm and then asked Sucran what was wrong. "Oh he throws up after every meal. It's fine."

After the women had finished with the *hoca* we asked Sucran (as her husband was not inclined to speak with us) about his practice as a *hoca*, how many people he helped each week, what he charged, etc. According to Sucran, men and women traveled from the far reaches of Istanbul to seek his services, and he usually treated six or seven people a week. There was no payment. In spite of this public service, Sucran's house was one of the poorest homes we had visited, and in dire need of repair and refurbishment. Both she and her husband suffered from various medical ailments (I believe he had a serious

stomach ailment, and she complained about asthma, a rash and arthritis). When I asked her if she and her husband made use of primary medical care, she said "Who has the money!" It was not on principle that they avoided going to the doctor, but for economic reasons.

After my visit with Sucran and her *hoca* husband, I began to read through the interview responses thus far to get a better idea of general attitudes toward this alternative healing practice. With the exception of three or four cases, most of the respondents denied ever using a *hoca*. Those who admitted to knowing about this practice always spoke in referential terms about family members and friends who had sought a *hoca*'s expertise in extreme circumstances. However, one woman I spoke with had been married for three years and had not been able to conceive a child. She had gone to fertility experts, stomach pullers (lay women who were experienced in matters of fertility), and finally and in desperation she had sought the expertise of a *hoca*. When asked if this had helped matters, she said she was still following his orders (which included prayer and a pious lifestyle), and she was hopeful that this would lead to fertility. When questioned about her husband and whether he had been assessed for fertility she laughed and said "of course not!." I would also like to note that while nearly all of the women I interviewed gave me a pat "no" to the question "Have you ever been helped by a *hoca*," additional information came to light when they were asked about their experiences with *nazar* and other supernatural forces. Several of the responses included seeking a *hoca*'s help when a child or loved one fell ill. It seems likely that this area of alternative healing caries a stigma, and though nearly all respondents were of a religious bent, social pressure to

discard local healing practices was so powerful that the open and "frontstage" attitude was that these practitioners were only for the uneducated. The "backstage" behavior, it seems, is a little different, and people are willing to use this service when other medical alternatives are unavailable, or ineffective.

Two Imams

In an effort to round out the religious aspect of my community study, my assistant Kaan and I found two *imams* who were willing to speak with me about the health status of their constituents. Among Sunni Muslims, an *imam* (from Arabic, meaning "leader") is recognized as a community leader and religious teacher (though this office is perceived differently by different Muslim sects, and in terms of leadership this is *not* a secular office, see Bates and Rassam 2001). His principle duty is to lead the Friday prayers at the mosque. Additionally, he is one who is very well versed in the Quran, and as such is respected among members of the community in matters of spiritual and moral importance.

The area of Kazim Karabekir Mahallesi is a rather undeveloped area of Ümraniye, as mentioned previously, and in addition to poor housing and public works, the area mosque was modest, without even a minaret (unlike the other area mosques which were grand and ornate by comparison). The mosque in my study neighborhood was a non-descript building, rather unassuming and easy to miss to an outsider. One day (this was in January of 2002) during the call to prayer I asked Kaan where the *muezzin's* voice was coming from, since I had not noticed a mosque in the area (a *muezzin* is a mosque official who chants out the call to prayer—generally over a p.a. system suspended from the

mosque minaret—five times a day and also at intervals on Friday. If there happen to be a number of mosques in a particular neighborhood these voices overlap and create quite a cacophony). We followed the sound and came to the aforementioned building. It was Friday, which is a holy day, and services were underway. We stood outside the building on the icy slope and waited for the *imam*. Eventually twenty or so men filed out of the building. There were three small boys playing and sliding down a steep hill just outside the mosque (it had been a particularly cold winter, and the ground was covered with snow and ice) so we asked them if they knew the *imam*, and they said yes. They found the man and we all made our introductions (incidentally, Kaan did the talking, since we felt it might be more appropriate). We found an area out of the wind, and the *imam*, Metin, and some of his friends stood by as Kaan asked general questions about health care and health status of the people in Ümraniye. By about the third question, which had to do with his involvement with the community, and his understanding of illness, etc., he began to ask me about my background and seemed nervous that I was asking so many questions. Kaan tried to explain the nature of the work we were doing to Metin, but he was clearly uneasy with the whole situation. He was a young *imam*, only around thirty years old, and his general comportment suggested that he was not at all pleased to be pressed by an outsider. Around this time another gentleman approached us, this one an older man (probably around 70 or so). He was very well dressed, and had a confidence and bearing about him that suggested that he was well respected in the community. It turned out that he was Metin's predecessor, but had reached a kind of retirement status. When he approached our group the other men immediately deferred to him, so Kaan made

introductions again (this other *imam*, Suleyman, shook hands with me, which the others had declined to do). He was very relaxed and answered our questions thoughtfully and candidly. Since it was an impromptu interview, standing on the icy slope, Kaan and I winged it, and when the interview was finished we headed back to his car and wrote up our notes. Suleyman spoke eloquently about the political problems and health problems his community faced. He also expressed sympathy for the September 11 events in the United States, and told me such things gave Muslims a bad name and he was sorry for that and sorry for the tragedies in the world. When I asked him about his community, and whether they sought his help in matters of health, he said yes, of course he had a finger on the pulse of the community, and was aware of who was sick, social problems and the like. But invariably he led the discussion to the political situation, and provided us with an interesting perspective on some of the psychological problems facing women in the Ümraniye area. Ümraniye, as I have noted earlier, is a conservative area. The women wear scarves and they conform to the standard of modesty that is expected in Islam. Many of these women would like to pursue higher education, but because the Islamic dress is banned in universities and other civil areas, they are essentially prevented from pursuing an education, as it becomes a choice between the social rules of the neighborhood and their religion and that of the Turkish government. As a result, a lot of these women suffer from a number of psychological disorders: insomnia, anxiety and depression. Suleyman mentioned that many of these women seek treatment at the local health clinic by way of anti-depressants and painkillers. Ultimately this does not solve the social problems they face, and it becomes a vicious cycle for them. This also has

repercussions on the community. This is a closely-knit neighborhood with a deep belief in their religious and family values, and the residents feel that the secular community in Turkey treats them like second-class citizens. One of the main points of contention about the headdress these women wear is the motivation: the Turkish government sees a political agenda, while many (not all) of those who wear traditional head covering, do so for more complex cultural and social reasons. Breu (1999:39) states that there are

> at least seven different stages in a woman's life designated by a headdress: young or engaged girl; bride; newlywed; young woman or mother; widow, including widow who wants to marry; old woman; and woman who mourns her husband's death or whose husband is abroad.

Additionally, each headdress fringe bears the signature embroidery of the woman who wears it. As I mentioned earlier, the *gecekondu* women are extremely skilled at needlework, and one sees in their exacting patterns and vivid colors a pride in their workmanship. This type of "country" headdress differs from another—one might suggest more political—variety of headdress which is made of nylon, not cotton, is store-bought, and worn by politically motivated Muslim women as a kind of uniform of solidarity. One sees the problem that faces a staunchly secular government that wishes to curb the tide of Islamist activity, but at the same time this secular government, that promotes democracy, denies legitimate freedom of expression to a large sector of the population.

When I asked if they had a political lobby for these issues, Suleyman told me that yes, of course they support those parties that are sympathetic to the Islamic agenda, and further added that this was in no way an extremist group, merely a group that wanted

freedom of expression, and the freedom to participate in Turkish government, politics, and other sectors without being persecuted. I asked Suleyman what he thought of the medical system in Turkey, and whether or not the *gecekondu* people received quality health care, and the whole group of men broke into laughter. He told us that the state hospitals were not adequate, that they were understaffed, and that often the people from his neighborhood knew very little about medical care and were therefore at the mercy of hospital staff–who he admitted were underpaid and undervalued themselves. He expressed a kind of fatalism about the whole system, and while he had a great deal of insight about the human condition, his community, and world politics, his frustration at not being able to make changes was apparent. We concluded the conversation and wished each other well.

Conclusion

As can be seen from the examples above, religion, as well as a related socio-linguistic domain, gives women within the regions discussed (i.e., rural areas, and areas of the gecekondu where rural migrants have made their homes), some sense of meaning and control over their environments. With regard to "superstition," an underlying logic serves to create an explanatory model for illness and misfortune. In terms of religious cohesion, a blanket of solidarity is created in the midst of the encapsulating secular milieu. Delaney (1991:284) summed up these ideological tensions nicely. With regard to secular Turkey's culturally Islamic and politically nationalistic population, she says:

The nation state confronts people as a competitor for their loyalty and affiliation, making it very difficult for them to keep religion and the state in their separate domains. Both are competing for total allegiance. The conflict occurs not because they are in total opposition, but rather because there has been a symbolic transfer from the realm of God, not only to earth, but specifically to the nation of Turkey; not because secularism has been empowered, but because nationalism has become the secular religion of the Sacred State.

CHAPTER 9
PROFESSIONAL HEALTH CARE IN TURKEY

Introduction

In Turkey there are 192 hospitals (reported in 1999), of which the Ministry of Health operates 31, and 12 are under the administration of the SSK (the social security agency in Turkey) (MOH 1999). In addition to these public hospitals, a number of privately funded facilities are in operation, as well as NGO-funded preventative health care clinics that serve their patients free of charge (though they can only offer limited services, prescriptions and referrals). According to the Ministry of Health (1999), they support

> A total of 213 basic health care stations, 19 neighborhood polyclinics, and 34 mother-and-child care centers throughout the province of Istanbul. The province has a total of 25 tuberculosis dispensaries and 24 general-purpose dispensaries run by the SSK. Polyclinics operated by private bodies number 186 throughout the province. The Red Crescent also operates a total of 20 polyclinics.

The health insurance system in Turkey is comprised of three social security organizations, which are: 1) The Turkish Pension Fund (Emekli Sandigi-ES), 2) the SSK, and 3) Bag-Kur, which is a corporation for self-employed individuals. Additionally there is a state run hospital scheme called the "green card" which is a health service for those who live below the poverty line and have no other type of insurance.

By looking at the raw medical resources, it seems that the public health system in Turkey is operational, and indeed every year steps are being made toward its

improvement. However, in terms of a total and quality health management system, quality health care has not yet become a reality for everyone who needs this service. During my stay in Istanbul, I had occasion to tour a number of medical facilities. I used this exposure to try to understand some of the problems facing medical personnel and the patients who rely on them. In this chapter I explore some of these facilities, and make observations about patient care, doctor's attitudes, administrative problems, and structural development and improvement within the medical system.

State Run Hospitals in Istanbul

Though reforms are being made each year toward better health care management in Turkey there are still administrative and personnel problems at every level. In the State run hospitals one finds a system of working chaos. The admission area is filled with patients and their families. The queues contain scores of weary people waiting to be evaluated by equally weary doctors. Family members–wives, husbands, brothers, sisters and mothers–move hither and yon with blood samples to (or from) the lab, because lab technicians are few and far between. The examining rooms are small and patients enter in quick succession, often receiving very little in the way of an examination due to the large volume of patients the doctor must see. During my tour of the Marmara Hospital one common complaint I heard (let it be said both among doctors and patients) was that due to these time constraints and medical shortages, only a terse exchange usually followed by a snap diagnosis is given. Often patients are given medications without any in depth gleaning of patient history. Very little in the way of explanation is given in

general, just a terse comment or two about the ailment and its medication. Outside the emergency room, various vehicles pull into the ambulance depository. The armed guards are very picturesque in their dashing uniforms. They stand with automatic weapons. Occasionally, the media appears with much flashing of lights and clicking. Caught in the strobe is a man who has been struck down in a traffic accident. He looks somber until faced with a camera lens, at which point he launches into a pained grimace and arms flail in unison. The photographers are pleased. Where are the ambulances? It is unclear. Doctors have mentioned to me that there simply aren't enough for a city of 12 million, so people make use of their own vehicles or taxis for this purpose...that is emergency rescue. I wonder if the taxis drivers are skilled at CPR or baby delivery or a host of other medical talents. They must encounter these trips quite frequently.

One of the doctors I've been "shadowing" ("Yilmaz") tells me that because of the economic crisis people are not able to get around as easily since things are more expensive, so they wait until a condition is critical, or either just go to the local saglik ocagi (public health clinic) to seek help. Indeed the hospital is used more as a public health outpatient clinic than an institution for more serious medical care. As I sit in the triage center a steady stream of patients enter and exit in quick succession. An old lady comes in complaining of chest pain, and midway through her explanation to the doctor a young woman wanders in with a test tube containing her husband's blood sample, which she is to deliver to the lab. She is pointed in the right direction and leaves. The old woman resumes with the doctor, but the tea man (personnel delivering coffee and tea to the medical staff throughout the day) has arrived and the conversation stops again. He

leaves and the woman attempts once again to explain her ailment. The doctor listens and then writes up a referral for further care. Now a man wanders in who has come on behalf of his son, who had a kidney disease. His face and comportment are set in a very submissive way to ask the doctor to help him get a spot for kidney dialysis. There is some discussion among the attending doctors and nurses in the room, as the man has not followed the proper chain of command to receive a referral at this hospital. He is sent back to the primary care physician to obtain clearance to be there. The emergency room doctor then takes me on a tour of the facility. Marmara Hospital is a beautiful old building, but antiquated, and in obvious need of repair and refurbishment. It was damaged during the last earthquake, as the telltale signs like cracks in the flooring and walls attest. We (my assistant Kaan and I) continue our tour with Dr. Yilmaz. He speaks very good English (fortunately for me), and he also seems to answer my questions candidly until I ask to see the facilities at the hospital. He tries to put me off, telling me that perhaps I'd like to tour the newer state of the art cardiac hospital instead. Finally I ask my assistant Kaan to explain that I wasn't there to judge, but to look at different types of facilities, and the real aspects of the situation. But the doctor remains guarded during the entire visit. Finally, after a rather brisk tour of the hospital, and diversions away from the more crowded areas, he leads me to back to the emergency room admission. When I notice the long queues and ask how long a patient generally waits before being seen, I am told 15-20 minutes. Obviously that would be ideal. But that was not the case in reality. This is yet another nervous defense to an outsider—which is very frustrating when one is simply trying to get to the truth.

Siyami Ersek Hospital (A Hospital Specializing in Cardiology)

In addition to the Marmara Hospital I toured a state hospital that specialized in cardiology (Siyami Ersek Hospital). Compared to Marmara, the cardiac hospital was positively palatial and state-of-the-art, largely owing to its funding from the Belgian government. When I arrived, I met with one of the nurses and asked her a few questions about quality of profession and general information about the hospital. She was polite but political, and I have to take what she told me with a grain of salt. If we take her testament as representative then all doctors make an acceptable amount of money, they are not overworked, working conditions are fine, and patients never cause any problems. After our brief chat, I had a different experience altogether with the technical director. He was a no nonsense type of director. He took me around the facility, answered my questions with honesty–so it seemed to me–and showed a degree of cynicism that I had not encountered among medical personnel in Turkey. At one point we took an elevator to one of the upper floors (seventeen if memory serves), and the elevator got stuck. I tried to swallow the fear that I would meet my maker in this way, stranded in an elevator. The technical director turned to me and said: "That's typical. This has been going on for months." When I asked if this wouldn't cause some problems when the hospital opened (it was due to open the following week), he shrugged his shoulders and said, "yes it will." He then shook his head in disgust and said that's how things go. He showed me some of the wards of the hospital, all equipped with state of the art equipment and new beds, and when I told him it was impressive, he said, "Yes, but I invite you to come back in one year. By that time the hospital manager will have let this all go." He was obviously

frustrated by the rate of attrition and mismanagement that one sees in the state run health facilities. To be fair this was a beautiful new facility. I was told that it had received funding from the Belgian government, and that's why it was in better shape than some of the other state run hospitals. He showed me the lobby, and it was elegant–a far cry from the bare bones facility one sees in most of the state hospitals. I told him it was gorgeous, but he practically spat and said: "Yes, this is where they spend all of the money, on appearances. This image is not what is important. It's care and support that are the important issues, but they want to show this new hospital off, so it has to look this way. My opinion is that people are sick when they come here. Anything is ok for them, but this elegance will be a waste on the types of people who will come here." A bit of class-consciousness bled through his critique, obviously, but he had a point about spending money on more worthy causes with regard to health services and benefits. I suppose this attitude–that is spending money on grand appearances for show case facilities–is not unique to Turkey. The following is a transcription of the statements he made during our tour:

Siyami Ersek Hospital is a special hospital for people with heart disease. It's a very big hospital and includes two buildings. One of them was just built and will be opened within the week. In this hospital is also an emergency room. 256 doctors and 125 nurses are working in this hospital. There are 180 beds. For each doctor there are two patients [general doctor to patient ratio]. There are three sections in this hospital: cardiology, heart and vein, anesthesia. Our patients usually come directly to us, because it's a special hospital for heart disease so everyone knows that it's the best hospital in Istanbul for heart diseases. Our patients are mostly insured. If I have to tell you a number I can say only 5% don't have insurance [This estimate is for the general population the hospital services and should not be applied to *gecekondu* residents specifically–though, some of those individuals would be referred to this facility as well]. We also have patients who have green card insurance. The age of the patients starts around 14 (no younger). They are usually between the age of 25 and 45. As the days go by the age gets less. We only had older patients five years ago, but now we also have

very young patients. The reason is stress, smoking and bad eating habits. Unfortunately there are not enough advertisements to make people realize that these reasons are bad for health and they should quit smoking and have better eating habits. But we have brochures (hand brochures) about that in the hospital. And also in TV shows the doctors talk about it and they warn the people.

We have enough doctors in our hospital but we need more nurses. We don't have male nurses. Our new building is brand new and it has the latest technology. The building has been built in three years. We took credits from the Belgium Bank for the expenses. So the lender is Belgium Bank, the borrower is the Turkish Treasury and the user is the Ministry of Health. When the construction started, the Ministry of Health wanted it to be as good as a private hospital. The building has eighteen floors. On the top floor there are two restaurants. One of them is a self-service and the other one has a la carte food. There are 200 seats altogether. This place is for doctors and for the visitors. But the administration decided to rent this restaurant to a private company. So it will be paid to eat and this will be an income for the hospital. Even this idea is not common for public hospitals.

The next floor has eight suite rooms and a nurse room. The suites are very luxurious and comfortable. They look like a nice hotel room. And the nurse room is for emergencies and for medications. We don't know the prices for these rooms yet but it will be between 70-80 dollars a night. We can't make the prices ten dollars because that way the expenses wouldn't match the income. The next twelve floors have standard rooms. Every floor has sixteen bedrooms. Thirteen of them have two beds and the three of them have single beds. The rooms have one bathroom and a television. These rooms are very clean and comfortable too.

In the other floors there are operating rooms. There are six operating rooms and these have the latest technology and the brand new medical equipment. Every operating room has two doors, one for the doctors and the other for the patients. And there are two operating tables, which match to each other. So they don't have to carry the patient. When one patient who is operated on will be going out, the other which is to be operated on comes in from the other door. There are approximately fifteen surgeries each day.

In the other floors there are intensive care rooms which also has the latest technology for the beds. There are twenty-six beds in intensive care, and two isolation compax. These beds are very functional. They can even weigh the patient. These beds cost around 7800 dollars for each. And there's a chroner for intensive care room. In this room there are six beds. In the entrance there's a nice lobby with leather couches. In this floor there's also an auditorium with 214 seats.

When we talk about the old building, there's an emergency room, a big intensive care room with 12 beds, clinics for out-patients, and rooms for patients. The patients come usually because of heart attack. There's a long line in front of the cardiology room. One patient waits for doctor's examination maximum thirty minutes.

Other statements made during our visit:

–The doctor says that there are a lot of educated people in Turkey, but not enough places to work.

–The foreigners do not want to make investment to Turkey

–All of our doctors are Turkish and most of them were educated in the USA

–We want the doctors to bring their patients to this hospital instead of taking them to a private hospital.

Observations at the Ümraniye Clinic

If you think being a medical doctor is always an elite and glamorous profession, you should look into the Istanbul contingency. Of course there are different levels (general practitioner, or specialists of various types, gynecologists, etc.) but the public health doctor is a heroic soul. He has no receptionist to usher his patients in, or to even schedule them for that matter. They show up, they take a number, and they enter in quick succession without so much as a moment to breathe between patients for the physician on duty. Literally, as one leaves another passes his predecessor in the threshold. Entire families descend upon the doctor, and given the volume of traffic he must make a relatively snap judgment, advise the patient, and write a prescription (if necessary) in a matter of minutes. I sat in the corner of the examination room during these visits (the patients don't care because there's no such thing as doctor-patient confidentiality anyhow), with the intention of studying doctor-patient relationships. I had envisioned lingering long to witness animated conversations, body language, etc., but as fast as I could write, they were out the door. Fortunately the doctor in charge knew enough English to clue me in when I got lost (e.g., this is an estrogen replacement menopausal

woman; this man has hypertension, smokes 2 packs of cigarettes a day...I said he should stop; this screaming child has an ear infection; this woman has lost an eye to glaucoma...). Not only that, but also many people were visiting on behalf of sick family members (this is quite common). There was some negotiating if the doctor didn't want to prescribe something without seeing a patient, but in general he gave them what they asked for. Throughout the chaos of general visits was the added distraction of waves of pharmaceutical representatives bursting on the scene to push antibiotics (grossly overused here), Prozac, urine specimen cups, medical Kleenex, and other items. On top of that, governmental inspection was going on (protocol inspection), doctor referrals (who expected to be able to cut in line because of acquaintance with important individuals), conferring doctors, telephone calls, and of course me in the corner. It is amazing that a doctor can juggle all of the above single handedly (Figure 11)!

Before embarking upon my mission to observe doctor-patient relations in the health clinic (July 2001), I met with a medical resident at Marmara University by the name of Nazmi, who was gracious enough to show me around Ümraniye and the health clinics where he worked (He was just completing his residency requirement and his M.A. in public health). First we met at Marmara University, and then took a bus down to Ümraniye. Then we went to the central health center for that area (Ümraniye Merkez Saglik Ocagi Labibligi).

Figure 11 Dr. Ali and Patient

I met the staff there, and toured the facility–a three story concrete building, and a "no frills" establishment. This clinic services the general public and also has a special family planning section. At that time (July 2001) the staff was attempting an outreach to the women of Ümraniye to educate them about family planning, birth control and pre-natal care (their focus was only directly concerned with women, though the doctors told me that they hoped the men/.husbands would be educated indirectly). The clinic we looked at also services the geriatric presence in Ümraniye, and the general population. The doctors at the clinic seem to work very hard, and in a very unglamorous environment. The top floor of the clinic is devoted to statistical analysis of outreach projects and epidemiological issues. After touring the facility we hooked up with two female doctors to do some follow-ups on family planning outreach. They had a kind of calendar

necklace to give the women of the *gecekondu* so they could track (or learn to track) their menstrual cycles. We drove to the northeast of an area called Kazim Karabekir Mahallesi, which is one of the most economically depressed areas in Ümraniye–a fairy well established *gecekondu* settlement comprised of migrants from all over Turkey. Dr. Sule (one of the doctors) dropped Nazmi and me off and we walked through the area so I could get an idea of the lay of the land. My first impression of the area was, yes it was poor, but the houses were better constructed than I had imagined. But Nazmi pointed out how the construction of each house was made piecemeal as materials became available–for instance, we saw many multi-storied terra-cotta brick houses that were in "transition" as the upper levels were being gradually constructed.

There were many children playing in the streets–also the odd cow or sheep, and of course many stray dogs. The women we saw were in conservative country attire, and some were in full chador. The only men we saw were the vegetable merchants who rode around on tractors selling watermelon, tomatoes, cucumber, etc. Dr. Sule found us after about an hour into our trek and took us to another follow up for the necklace outreach. She asked if I wanted to accompany her into the woman' house, and of course I said yes (Nazmi had to wait in the car because the male presence was not welcome). The woman we spoke with made very sure to pull her scarf completely over her face in front of Nazmi. We entered a small concrete house, and took our shoes off–as is the custom when entering a house in Turkey–before entering the living room. The first thing that struck me was how clean it was. It was carpeted with kilim rugs and while it wasn't a glamorous home, I thought it was well furnished and very "homey." I had envisioned

complete squalor after the descriptions I had heard of and read about the *gecekondu*. Dr. Sule asked the woman a number of questions, gave her some condoms, and we left. The woman she interviewed seemed very friendly and gregarious, and seemed to have no problem discussing intimate sexual details with Dr. Sule. We left and then all headed to another clinic, this one in the Inkilap region of Ümraniye. This was basically the same set up as the one we visited in Ataturk, but on a smaller scale (I learned that their staff consists of one male nurse–one who does only paperwork and immunizations–two doctors, eight nurse midwives). This is about four miles from the *gecekondu* settlement we just visited and is the only clinic available to those people. The following week, after I became acquainted with the health clinic staff and the population it serviced, my assistant Kaan and I met with the head doctor at the health clinic (Dr. Ali) and began the clinic observations. Listed below are a number of cases I was able to observe. I have taken these cases directly from my notes (some shorthand is used) to give a rough idea of the rhythm and pace of the clinic, and how the patients were managed (note: average length of an examination was 3 minutes):

1. Man comes in. He explains his problem and presents a box of medication he has brought to the doctor. He wants the doctor to prescribe more. Dr. enters this into the log and writes up another prescription. All done while he is on the phone with someone else. Very little communication, and the patient is very quiet. No eye contact. Patient is very persistent about a specific drug. He is also nervous.

2. 55 year old man comes in with a younger man, but then the younger one leaves. Active conversation between the doctor and the patient. Much eye contact. Dr. takes his blood pressure, which it turns out is very high. Dr. prescribes and carefully explains the medication to the man. The patient answers and asks questions actively. BPH and hypertension drugs prescribed. In the meantime a pharmaceutical representative has entered, today promoting antibiotics and Helcion (for ulcers). Doctor asks questions very

quickly. This man was using unnecessary medication and doctor cancelled the antibiotics. Patient didn't take proper medicine. Blood pressure was high and the doctor writes two new prescriptions.

3. 45 year old woman. She is conservatively dressed. She is here on an emergency visit. She seems to have hurt her leg, and the doctor explains that she's an osteoporosis patient. She is given a prescription, and makes lots of pained grimace faces throughout the visit. Also during this time a nurse visits the doctor and they chit-chat at length while the patient waits. Now the doctor sits down and asks questions of the woman. She answers quietly and asks a few questions, then waits quietly as the doctor writes up her medication. She leaves quietly.

4. 40 year old woman with a young boy. They have been sent back to the doctor from the pharmacist. Something about the prescription is not right. Doctor asks her to remove her coat and sit on the examination table. They set up a privacy partition since Kaan is in the room as well. The doctor begins the examination. He feels around her abdominal area, and the woman and the doctor speak the whole time. The exam lasts about 45 seconds. The woman presents her old prescription box covers and the doctor writes a new prescription for her. The woman talks throughout, with the doctor prompting her here and there. She is very vocal and begging the doctor to write a prescription. Asked if she has edema. Wants medicine. She probably has a stomach problem. Doctor refuses med.

5. 35 year old woman. She is in on her mother's behalf (her mother has Parkinson's disease). But there is a problem, so the daughter gets medication for the mother. The medication is very expensive (300 dollars), but the doctor is in a friendly mood and gives her the prescription for free. The woman is mostly quiet but answers questions when asked. Her mother also has hypertension, for which she receives a prescription. The doctor seems nervous and stressed now. The woman asks the doctor if she can get some more information (literature) on her mother's illness (Parkinson's). Doctor makes some recommendations. The woman also asks for medications for her father, but the doctor refuses, insisting that he come in person.

6. This is a hypertension case. Also thoracic trouble. He has come from a specialist center in Istanbul. Also a fairly young woman enters, who has also lost an eye to glaucoma. Mainly she wants some medicine. Doctor mentions to me that she is a chronic drug user and it is affecting the function of her stomach. He prescribes the medication anyhow.

7. 38 year old woman waits while more pharmaceutical representatives speak with the doctor. They seem to come throughout the day to promote their products. A woman and child wait quietly for the doctor to see them. She is dressed very conservatively. The woman wants a prescription. Aside: glaucoma woman re-enters because she needs a different prescription. Now the room is filled with people wanting revised prescription.

They leave. The patient finally gets a chance to speak and begins to explain her problem to the doctor. She is immediately interrupted again as another pharmaceutical representative and another doctor enter to discuss a problem. They seem to resolve it and finally leave. The representative was a control agent checking books. Apparently he found some inconsistencies. Now the patient is explaining her problem again. She coughs, and seems to communicate well. She sits on the exam table and the doctor checks her throat with a tongue depressor. She answers specific questions and holds her small child all the while. Doctor quietly writes up a prescription and stamps her prescription book. The woman is begging for a prescription. Also requests medication for her sister but the doctor refuses the sister.

8. Older man. He has an orthopedic problem of some sort. He sits on the examination table and the doctor instructs him to move his arm around in wide circles. He has osteoarthritis. He is advised to work his arms to loosen them up. This patient has been smoking for 45 years and smokes 1 and a half packs a day. His daughter and a young boy are in the room throughout the exam. The man coughs violently as the doctor probes. The man also has asthma. The doctor writes a prescription and gives advice. The man is told to avoid the teahouses, and all the secondary smoke there [I assume this was to lessen the man's guilt, and prevent him from the excesses of smoking socially in that environment].

9. 63 year old man wants a prescription. Questions are asked. The man is very communicative. He knows his problem, knows his medication, and wants to get the specific medication and leave. He seems very much in control of his situation. The doctor, in this case, complies. Indeed in general he seems to be at the mercy of his patients. This is a really break neck pace with patients, representatives, doctors and officials. Patient leaves.

10. 51 year old woman waits as the doctor finishes his phone call. [When the phone rings this seems to be the only time that the doctor gets even a small break.] The woman tells her problem. She has osteoporosis and is going through menopause. He puts her on calcium and estrogen replacement therapy. [Another patient interrupts with a problem and then leaves abruptly]. The patient is quiet but seems to communicate well. The doctor writes up a prescription.

11. 42 year old man with 3-year-old son enters. He just wants a prescription. The doctor tells me this is another chronic drug user. The doctor writes up the medication and the patient leaves without further comment. Man suffers from depression and insomnia.

12. Woman with a young daughter (maybe 3 years old). The girl has an ear problem. The baby doesn't want anything to do with the doctor. There is much screaming and hysteria but they hold her down and examine. The longer the examination lasts the more hysterical the child becomes. The doctor tries to be funny and entertain the child, but to no avail [mother's hands are henna stained]. Dr. writes up a prescription.

13. A man comes in on his mother's behalf. She has rheumatism. Doctor writes up a prescription. The man says nothing throughout, then takes the medication and leaves without comment.

14. 42 year old woman with a problem. The pharmacist wouldn't take her prescription.

15. 55 year old woman. She has a sore throat. She sits on the examination table, chatting the whole time. The doctor checks her throat and takes her blood pressure. She is quiet during this time. A representative enters too, pushing Prozac and antibiotics. In the meantime the doctor writes the woman a prescription. More traffic. The representative talks some more. She patient also suffers from insomnia and nervous disorder.

Another day:

1. Patient taken into the examining area. Woman is apparently very ill. She has been vomiting. Doctor comes in with blood pressure cuff. As he's taking the pressure he calls her *Teyze* (Aunt, mother's sister), lessening anxiety? Doctor seems very concerned and helpful. Lots of communication both ways. The doctor logs her pharmacy book and writes up a prescription. The woman has no family and has had this problem for around 7 years. He finds medication from sample stock and gives it to her.

2. Nurse who works in the clinic comes in with a problem. Doctor writes up a prescription. Insomnia.

3. Woman in conservative attire, around 35 years old. Doctor writes prescription, she stands the whole time. Very brief exchange.

4. Man with flu and headache, around 50 years old. Doctor checks his throat and blood pressure, and then writes up a prescription. Man sits down, he's very quiet, and "sniffly". Doctor explains medication and how to take them, asking about existing health conditions.

5. Young woman in western attire. She's around 22 years old. She has lost her first baby due to -Rh factor – erethroblastosis fatalis. Now she's getting an injection with the Rh serum to kill the -Rh. She seems very enlightened about her condition, and also the intricacies of the blood problem.

6. Older woman with eczema comes in. She is immediately told to go to the pharmacist to have something mixed for the rash. Very brief exchange.

7. Woman in conservative attire (and designer bags and shoes) around 28 years old. She stands the whole time and the doctor writes her the prescription she requests. Very brief and terse exchange. In the mean time 2 more pharmaceutical representatives come in with goods.

8. Older woman enters as the representative continues. She's around 60 years old and suffers from hypertension and osteoporosis. She is also diabetic. She says "yok yok" (she has everything!) This is type 2 diabetes. She is obviously quite used to the doctor and the doctor and she are quite communicative.

9. 35 year old man. Very quick 1 min exchange for a prescription.

Another day, working with a female doctor:

1. 50 year old woman in conservative attire. Also the pharmaceutical representatives have entered again. Doctor gets down to business and writes her a prescription right away. She has hypertension. Very terse exchange though polite. Patient seems a little nervous and worried. Wants pain killers and something for goiter. Also hormone test results. Wants to know about surgery for goiter. If medication don't work... The woman is obviously afraid of surgery. Doctor is friendly and calming and takes time to explain the medication.

2. Woman with a small child (about 1 year old) and also her mother. She seems very poor, but has a cell phone. The baby is not happy to be probed. Baby is put down on the table and examined. Stethoscope, tongue depressor. She makes her diagnosis after looking at the baby's throat. Sore throat. Doctor writes up a prescription. There is a friendlier dialogue between the two. This is a nurse. She is sent to the hospital. Attitude: woman explaining with a lot of body language and "attitude" [Kaan whispers to me that this is the case] that the baby was ill and it's not her fault. Very concerned that doctor thinks she's a good mother.

3. Middle aged woman in conservative attire. Pharmaceutical representative re-enters as well. She brings her old prescription packages. Seems to be a doctor referral. The doctor writes up for new medication. Not much is being said as she writes up 4 prescriptions. Throughout the pharmaceutical representative is pushing "hyperium" for hypertension. Doctor says she might be addicted to nerve medication. Doctor emphasizes that hypertension medication must be used regularly.

4. Older woman (80 or so?) She seems to want a prescription re-filled. She explains lower back problem medication that she wants. Lots of communication between the two. Lots of participation on both sides. Doctor more reverent because of her age. Kaan tells me the woman is being nice but kind of fake with the doctor. She wants to switch medication. Was talking a lot to the doctor, but the doctor was not talking a lot back.

5. 37 year old woman in conservative attire. She seems to have many hospital referrals. Wondering: are histories of medication at all computerized. Patient and doctor are very friendly and chatting.

6. Woman who has had heart surgery (can see the scar along chest, as her blouse is of the button down variety and not completely buttoned), comes in with a more conservative woman. Another pharmaceutical representative also enters the room. Woman appears to be around 40 years old. She is very talkative and is complaining with force and animation. She says the medications don't work. The condition has worsened. Much eye contact. Negotiating. Women are dressed in western attire. She talks a lot and is very communicative. Patient is the first I've seen who is the one in control of the exchange. The doctor eventually writes, yes, another prescription. The pharmaceutical representatives and the other woman wait quietly this time. [Incidentally, when the woman's throat was checked the throat contraption was not cleaned.] Pharmaceutical representatives seem at a loss and turn to me to bestow a promotional pen. I accept gratefully, always happy to receive office supplies.

7. Woman in western attire has been referred from Marmara University. She needs signatures, but for what? Uses actual carbon to duplicate the document. Not sure what this is about, but the whole exchange only takes around 5 minutes.

8. Older gentleman (65 years old) dressed in country attire. Doctor asks how he's doing. The patient is very quiet unless he is asked a direct question. Doctor takes her time explaining things to him. They joke a bit and this seems to relax him a bit. He gets onto the examination table for a prostate exam. She tells him about some medication, and though he is unsure and doesn't seem to understand, she takes her time and explains thoroughly. She seems reassuring. The man came in sounding worried, but the doctor seems to have put him at ease. They discuss the prescriptions. He doesn't seem to mind that there are people in the room during the sensitive exam. Lots of back and forth exchange. Whole exam takes around 13 minutes (one of the lengthier exams). Older man is having urinary problems. He's been taking medication for 2 years, but doctor says he doesn't use it properly. Patient says that after prostate surgery bleeding. Doctor says not using the medication properly is a problem. He also has a hearing loss and she checks this with a pitch. Wants him to have his prostate checked again. Man is very shy and the doctor very patient with him. Always he averted eyes and had closed body language.

9. Another older gentleman (around 70 years old). He has an empty tube of something that he wants refilled. Vermidon. Migraine medication. She asks if he has stress or high blood pressure. She is asking about precondition for the medication. Doctor is nice but clearly in control. (Previous patient re-enters wanting her prescription written).

10. 50 year old woman in conservative attire enters. Another pharmaceutical representative has also entered. Lots of flipping through the patient's prescription file.

Lots of silence throughout this exchange. Seems to have lower back pain (patient points to her backside and the areas that are giving her trouble. She seems exasperated.) Doctor says very little, and makes little eye contact for the exchange. Kaan tells me that the patient is a little off-putting. Crying wolf.

11.Woman in conservative attire, around 35 years old sits patiently while yet another pharmaceutical representative pushes his product: Claritin. Also some other anti-allergy medication. Representative finally leaves. Virtually nothing said between patient and doctor as she looks at the prescription. Whole exam lasts 3 minutes.

12. 19 year old woman. She wears a headscarf, but is otherwise in western attire. Another pharmaceutical representative enters. This woman was referred by the Marmara University Hastanasi (Hospital). Little is spoken and the whole exchange takes 2 minutes. She is having psychiatric and dermatological problems. Doctor can only do one referral so sends her to the dermatologist.

13. Modern [attire]looking man enters. He's around 60 years old. Another representative has entered and is pushing antihistamines. Patient only speaks when spoken to. Doctor engages him visually and seems quite personable. He is silent, but seems relaxed. Doctor looks something up in a book. The treatment. [Dr. Ali pops his head in to say he's going home. He doesn't look well at all. Think he has a nasty bug or flu]. Pharmaceutical representative continues to wait. They are like vultures. Another one enters pushing antibacterial ointment.

14. Young man enters in street attire. He is asked to do a series of squats and then his chest is listened to [Dr. Ali has come back and has taken control of this transaction. He listens to the patient's back and then leaves.] This man is in for a physical fitness exam for work. [In the meantime a woman has entered and waits to be seen.]

15. A woman in conservative attire enters with a young girl who is wearing a band-aid on her chin. The woman is very communicative and comes in talking. She seems in control of the situation. The doctor is very nice to her and it seems a pleasant exchange. Doctor asks about existing conditions and goes over medical history in the prescription book. Now silence. Whole thing takes 4 minutes. Dr. Ali has reappeared and tells her to use for her allergy: garlic, aspirin, and onion. And she also needs a cream and injection. Patient says she doesn't think the cream works. More pharmaceutical representatives enter with much kissing and hugging. The pharmaceutical representative is a loud woman and rather hyperactive. Much banter and front stage joking. Cacophony.

Conclusion of clinic observations

With an average examination time of three minutes per patient each one entering and exiting in quick succession, it was clear that time constraints, medical staff shortages and an influx of patients seeking relief from a variety of ailments created a recipe for superficial medical care. The doctors appeared (and admitted to being) exhausted by lunch time, and given the cursory attention to medical histories that I (with the aid of Kaan and Dr. Ali) observed, it seemed that patients learned that pharmaceuticals were the most expedient means of treatment. After witnessing a number of transactions between doctor and patient, I realized that the latter was not satisfied until he or she was sent away with a prescription of some sort. While the doctors admitted that they needed more time to fulfill the preventative care agenda in which they believed, this was not a day-to-day reality. During these observations, men and women, old and young visited the clinic for treatment; and while there were some visible differences in social and economic station among these people, in general they lacked the resources to seek treatment from a private facility or family doctor, and were therefore at the mercy of a poorly administrated system.

Contrary to my preconceived notions about men and women in the "sick role" (i.e., that women would be more passive since the more conservative population I studied was a male dominated social system), men were generally more shy and reserved, and they were generally less articulate when describing their ailments than were the women. While there was some variation among the women (some were more reserved than others), in general they described symptoms as well as their opinions quite openly and

were also more inclined to exchange banter with the attending physician. I also noticed that women seemed much more adept at negotiating with the doctor when he was not inclined to give them what they wanted (e.g., medication for a sick family member, or a refill for a prescription). In this respect, body language was another obvious difference between male and female patients. Men tended to be more withdrawn, sitting quietly or agreeing readily with the doctor, while women–even those who were somewhat reticent–would openly show pain, emotion and discomfort to get the point across. It was interesting to note that the same women who declined to be interviewed with Kaan in attendance (more accurately, they were from the same area I sampled), were completely unguarded in the clinic environment. Even though my assistant Kaan was in the room with us the whole time, these women were not bashful about going through physical exams and discussing bodily functions and the like in his presence. My feeling is that decorum and etiquette in the neighborhood is one thing, but when it comes to taking personal agency to find relief from a medical complaint, women feel free to open their boundaries to get what they need.

Of additional interest to me was the variety of complaints experienced by the patients of this clinic. From common cold and flu to psychological disorders, patients took agency and sought a cure for the ailment. One puzzling question that remains for me is why there are so many chronic drug users. During my visits Dr. Ali told me of many cases of drug misuse, and in particular overuse of antibiotics. Since patient histories are not routinely checked, this would seem to create a great danger for those who know very little about the effects of using antibiotics chronically, and indeed the

physicians are well aware of the problem. Again, because of the lack of resources at this level of care, the objective seems more to treat the patient–in terms of expectation–than to treat the disease.

Dr. Ali told me his income was around $300 a month–a figure corroborated by Drs. Gurcan and Dilek (more on this below). With so little incentive and harsh working conditions, one sympathizes with these doctors and the choices they must make; however, there were many occasions when a doctor would mention to me that a particular patient misused or chronically used a particular drug, even as he wrote out a re-fill for that prescription. With so little available to the patients in the way of primary medical care, it seems that they have learned to demand medications, and do so vigilantly as their only recourse.

Interviews with Doctors

While conducting my studies at the public health clinic, I had occasion to speak with several doctors who worked at the clinic. The main doctor I worked with was Dr. Ali, who was a beleaguered soul, over-worked and underpaid. During our chats, he told me a little about what was involved in being a physician in Turkey. Dr. Ali had gone to medical school at Edirne University, after which time he did his two year internship. Following completion of his M.D. status, he moved to Istanbul to pursue an M.A. in public health. (I asked him a little bit about HMO's, an up and coming concept in Turkey). He informed me that at this time health care management was still at a rather basic level, though improvements were being made each year. According to Dr. Ali there

are 260 mini-clinics in Istanbul (a slight variation from the Ministry of Health tally, which was written in 1999, see page 1 of this chapter), fourteen in Ümraniye. Most of these centers still operate as walk-in clinics for those who have no health insurance, therefore funds are limited to operate these establishments, and since resources are low, medical staff is underrepresented.

Another physician at the Ataturk-Ümraniye clinic was Dr. Gurcan. He was a regular doctor at the clinic. At the time of our conversation I did not understand much Turkish, he knew very little English, and we both spoke very little French, but we were able to piece together an interview using all of the above languages. In particular, I asked Dr. Gurcan about work conditions for physicians in Turkey, and he was quite candid about some of the pitfalls of the profession, and also misallocation of medical funds. In particular, he felt that there were not enough facilities for general practitioners, as most of the funds seemed to go to high profile specialty centers, like MRI clinics. This, he felt, was a ridiculous number, considering the need for basic primary health care at the practitioner level. According to Dr. Gurcan, "[There are] many medical facilities in Turkey, but not enough qualified professors, also the final exam is very difficult to pass, and the number of years (6+) of study is quite long. And at the end of it all the pay is very low, so there is very little incentive to enter the medical profession." He told me that 20 years ago the medical profession was a prestigious vocation, but now it has been taken to one of the lowest rungs as a vocation. His colleague Dr. Dilek, who is both a medical doctor and the Director of Public Health Services at Marmara University, corroborated this view. Her interview follows.

When asked about the pharmacy strike, and the reasons for it, Dr. Dilek told me that real prices have to do with the pharmaceutical companies. Also the Ministry of Health tried to cut prices by 10 percent. If you have insurance, 90% of the bill will be paid by the government. So the pharmacists would have to pay for the remaining 10% and there would be a profit cut for them.

S – And how many of the patients at the saglik ocagi [health clinic] are insured?

D - About 90%. Uninsured don't pay at all. The health center is legally free, though we do charge a donation. No money for child health care, immunization. For civil workers it is covered almost completely. Those with SSK (social security) have their own health care facilities. There is also the Green Card. Only the poorest people get this (they can come to the health clinic too, but must get referral from the health center to see a specialist.) The Ministry of Health should provide money but doesn't so health centers rely on NGO's. Primarily the Saglik ve Social Yardim Vakfi (Foundation for Health and Social Assistance, which is a national foundation with different branches. They can take 90% of the donations and pour them into the clinics, but must give 10% back to Ankara (i.e., the central government). There are signs posted throughout the clinic for these donations.

The Green Card carriers use the State Hospitals. Hospitals don't want to admit them because they're not yet referred from Primary care. This referral chain only works for the Green Card holders. It's the same system for the SSK people. At the University level, any civil worker or anyone who has made a protocol is covered. There are 15 public health centers in Ümraniye.

S- What are some of the more common medical complaints that you get at this level?

D- Some seasonal problems in the clinic: for winter mainly upper respiratory infection. For children flu and ear infection. In the summer: diarrheal diseases. Some houses still use well water. Also foods are a big problem, particularly unwashed salads and fruits.

S- In terms of prescription medication, do you find that patients follow the directions and take these medications properly?

D- There is a real problem with this! Particularly on the Doctor's part. They are not explaining this well enough to the patients. There is a theory of "good prescribing practices" where each doctor should spend a recommended amount of time with a patient. Unfortunately, with so many patients to see this gets cuts down and not enough time is spent describing the diagnosis and the treatment. Our version of the FDA requires instructions on boxes but it's not in a common language and just panics a lot of people. Also, the eczane [pharmacies] don't provide clear directions on how to take a medicine on the package. There are also some problems with antibiotics and non-steroid anti-inflammatory drugs. If the doctor doesn't ask the history he just keeps refilling a prescription. Patients are just told yes or no without any real explanation.

S-What are the types of health personnel you employ here at the clinic?

D- 1 male nurse (injections, trauma, keeps records, books, etc.), 3 female nurses, 8 nurse midwives, 1 secretary, 2 cleaning ladies. Also, the nurses and midwives make house calls. The message doctors give is that all deliveries should be in the hospital. Midwives follow-up and advise for hospital delivery. But mothers aren't forced to go to the hospital. Incidentally, "withdrawal" is the no. 1 method for birth control here. It's used

by 24.4% of all married couples. 98% of the people know at least one other form of birth control but still use withdrawal. There's a saying here that "If a man cares about his wife he uses withdrawal" also there is a widespread belief that monogamy protects from HIV and other STD's which may account for the much lower incidence of these afflictions in Turkey. If one is "kizli" then one's blood is tainted.

S- In terms of workload for you, do you feel that these health centers are adequately staffed?

D- Clinics are understaffed, especially in terms of midwives, because it is more about prevention than treatment. Nurse-midwives are more important in primary care than doctors. Also low because the Ministry of Health has more funds for two-day hospitals than for the health clinics. People don't appreciate preventative health care. Think of the train and the rock.

[Dr. Dilek told me this story: in a small town in Turkey there was a railroad. Every day around 2 p.m. a train would pass through the town and make its way to its destination. The train passed right through the village, so the passengers never even realized them there...it was just some more scenery along the way. One day just before the group of villagers made their way to the fields to harvest they noticed that a large boulder had rolled down from the mountain and had landed right on the tracks. They immediately approached the boulder and with a great deal of effort were able to move it from the tracks just as the train pulled around the bend. The train passed by, and none aboard were aware of their close encounter with tragedy. Dilek told me that her staff and the

preventative and outreach work they do is a little like that: people don't know how their lives are diverted from real health problems because of these efforts.]

D-Also, the staff is extremely underpaid in the clinic. They dream of becoming a specialist and earn more money and respect (as was the case about two decades ago.). Incentive in Turkey may be an idealistic "I want to help people" (can become a medical doctor at age 24 or so). But on the way, realize you don't make enough money, and no positive feedback. Law #224 is the main law of the health system (referral system). When it started the government prioritized primary health over hospitals, and paid doctors in primary hospitals more–more status symbols, money and power, and lots more money than colleagues in hospitals. But this changed because the government prioritized hospitals over primary health care. It's political. If a person is not elected for M.P. then they may be given a directorship of health in a city as compensation. The Turkish Medical Association fights for better salary and conditions, but they are not allowed to strike or bargain for wages. (The pharmacists are private and can do this–strike that is). But they have more pragmatic ways of doing this such as slowing down their routines, and seeing only a few patients a day, and create a feeling of unrest and impatience.

There is really very little communication between the doctors and the pharmacists. Doctors are upset that the pharmacists give patients certain drugs without prescription, especially antibiotics. Usually it's the clerks and not the pharmacists who hand out these drugs. These people are not properly educated and make discretionary choices on their own. The TTB [Turkish FDA] is trying to regulate use of antibiotics, since as of right now one can get any kind of medication readily with the exception of

narcotics. Narcotics are regulated. But antibiotics are the most overused over the counter drug in Turkey. Most people take antibiotics for viral infection. There is a great deal of misinformation and misguidance though [end of interview].

Dr. Dilek and the other doctors I spoke with were forthcoming and seemed to really answer the questions put to them in a non-political way. In particular, I would characterize Dr. Dilek and her colleagues as physicians with a genuine interest in improving public health care–both from the perspective of the doctors who are trained to do so (creating better facilities, better training, greater empathy, better benefits for those doctors), and in terms of the patients they treat. Dr. Dilek, in particular, was well informed about and empathetic toward the gecekondu patients, which I attribute to 10 years of outreach participation with these people through the public health center at the Marmara University.

Pharmacies in Istanbul

One of the most conspicuous distributors of over the counter and prescription medication in Istanbul is, of course, the pharmacy. January 2002 was a unique period for the Union of Pharmacists. It was marked by many protests and a boycott as a result of dissatisfaction with government control over medications. In particular they were upset over "negative conditions in their profession, delays in payment by the public institutions and decreased profits due to imported drugs" (Turkish Daily News, January 11, 2002). In order to express this dissatisfaction, a public meeting was held in Eminonu district of Istanbul, where hundreds of unionists gathered to show support, and also to sign a

petition to be sent to the Ministry of Health. It was felt that a governmental extortion of drug prices was taking place, with the Ministry of Health trying to cut prices by 10%. Since for those who have insurance, the government pays 90%, pharmacists would have to pay the remaining 10% by a profit cut. I literally stumbled onto this protest when my photographer Kaan and I were making our way to the spice market to take some photos of herbalists and their wares. We passed by the main post office and found a huge mob assembled there. The media was also present, along with many folks in white lab coats distributing a petition against governmental policy with regard to pharmaceuticals. We took the opportunity to take some photos (see Figure 12), and also to question some of the pharmacists in attendance. This group was well organized, and vocal, and seemed eager to be heard by media or anyone else interested in their plight. My personal experience with individual pharmacists was much different, as they were generally reluctant to speak with me (more on this below).

Figure 12 Pharmacy Union Protest (January 2002)

While my interest in the administrative aspect of the health care system, with regard to pharmacies also contributes to this study, a more important issue to me was the types of medications that are being sold to the focus population (Ümraniye *gecekondu*) and also some of the attitudes pharmacists have toward distribution of these medications. Using a door-to-door sampling method, I visited as many pharmacies as possible in the Ümraniye area, and just beyond its periphery. It was somewhat unfortunate timing to start these interview rounds just before the boycott (an event I didn't realize was about to occur), and many of the pharmacists with whom I spoke were rather reluctant to provide information, assuming that I represented the media, and intended to probe into the more union oriented issues circulating among this group. In many cases, the moment we (my assistant Merve and I) entered a shop, the pharmacist would affect a very intolerant stance and inform us that he/she had nothing to say to us. However, we were able to find a few willing (albeit recalcitrant) individuals to speak with us. In all, twenty-nine pharmacists were interviewed about a number of topics, ranging from most frequently prescribed medication, to the most commonly purchased over the counter medication. I did add a question to my interview schedule to include the pharmacists' feelings about the boycott and also if they felt vindicated by the results of their protest. The brief interview schedules conducted with the pharmacists were designed to garner their impressions about their clientele. All data and frequencies reflect the pharmacists' opinions rather than empirical data. The impressions are important in that they provide another health sector perspective about the *gecekondu* residents and their use of medication. The results of the questions posed around Umraniye correspond with results

in a help-seeking behavior study by Hayran et al. (2000), who found that analgesics and expectorants ranked among the highest consumer items in the area of self-medication. Further results from the present study are shown below.

In Table 16, the results show the frequency of certain over the counter medications according to the pharmacist. I found that among those questioned, it was felt that most patients bought pain killers (59%), while the second most requested OTC drug was believed to be cold medication (38%), followed by antibiotics (though they are supposed to be a prescribed drug, they are often dispensed without a prescription). Another question of interest to me was which OTC drug was, in the opinion of the pharmacist, overused or misused by the general population. Pain killers (45%) were most often cited, followed by antibiotics, and interestingly 3% of those questioned felt that all medications were misused and abused .

Table 16 Over-the-Counter Medications Pharmacists *Feel* Are Most Frequently Used and Overused by *Gecekondu* Customers (n=29)*

Medication Most Used	Frequency	Percentage	Most Overused	Frequency	Percentage
Pain Killer	17	59	Pain Killer	13	45
Cold Medicine	11	38	Antibiotics	9	31
Antibiotics	14	28	Vitamins	5	17
Vitamins	4	14	Cold Medication	2	7
Fever Reducing	3	10	Sleeping Pill	2	7
Anti depressant	2	7	None	2	7
Stomach Pills	1	3	Cough Syrup	1	3
Rheumatism	1	3	All Medications	1	3
Hypertension	1	3			

*Multiple responses.

When questioned about frequently prescribed drugs, antibiotics were most frequently cited (at 55%) followed by cold/flu medications (41%) and then pain killers

(31%). In response to a question about which medications that don't require a prescription should require one, nearly half of the respondents cited antibiotics, at 45%. Also included on this list were vitamins, cold medicines, and 3% of those questioned on this topic felt that all medications should require a prescription, while 7% of the pharmacists felt that no medication should require one (Table 17).

Table 17 Prescribed Medication Most Used by *Gecekondu* Customers/ OTC Medications They Feel Should Always Require a Prescription. According to Pharmacists. (n=29)

Prescribed Medication	Frequency	Percentage	OTC That Needs Prescription	Frequency	Percentage
Antibiotics	16	55	Antibiotics	13	45
Cold Medicine	12	41	Vitamins	4	14
Pain Killer	9	31	All	3	10
Diarrhoea	2	7	Cold Medicine	3	10
Fever Reducing	2	7	Sleeping Pills	3	10
Antidepressant	2	7	Pain Killers	3	10
Hypertension	2	7	None	2	7
Rheumatism	1	3	Rheumatism	1	3
Throat Spray	1	3	Hypertension	1	3
			Heart Medication	1	3

Table 18 shows the percentage of women and men whom pharmacists felt utilized pharmaceutical services most. The majority of those I questioned felt that the men/women ratio was fairly even, though these figures changed somewhat among other pharmacists, with 3% stating that 80% of their clientele were women, and 7% stating that only 40% of their clientele were women (other responses are indicated in Table 18). When asked about the socio-economic levels of their patrons, 52% felt that the middle class were most represented, with only 5% catering exclusively to the lower SES levels, and number of others had a mixed distribution in this area (Table 18).

Table 18 Perceptions about the Ratio of Women/Men Seeking Care at Pharmacies Used by the *Gecekondu* Customers and Socio-Economic Status (SES). (n=29)

Average ** No. Women/Men	Frequency	Percentage	SES*	Frequnecy	Percentage
50/50	13	45	Middle	15	52
60/40	10	35	Lower	5	17
70/30	2	7	Upper	3	10
40/60	2	7	Mixed	1	3
75/25	1	3	80% higher level	1	3
80/20	1	3	50% low/ 50% high	1	3
			20% low/ 70% mix/ 10% upper	1	3
			70% middle/ 30% lower	1	3
			80% middle/ 20% lower	1	3
Total:	29	100		29	100

*Respondents characterized SES in different ways, and each type of response is recorded.

When these pharmacists were asked to estimate how many of the patrons were insured and uninsured, answers were variable as well. Seven percent of those questioned mentioned a rate of 100% for uninsured patrons, while 17% stated that 100% of their clientele had insurance. The full range and combination of medically insured individuals, by the pharmacists' estimates may be seen in Table 19.

Table 19 Health Insurance among *Gecekondu* Residents with Estimated Rates of Health Insurance by Pharmacists. (n=119)

Health Insurance*	Frequency	Percentage	% Insured**	Pharmacists	Percentage
None	80	67.0	90	8	28
SSK	31	26.0	100	5	17
Government	4	3.4	80	3	10
Bagkur	3	2.6	70	3	10
Green Card	1	1.0	60	2	7
			50	2	7
Total:	119	100	0	2	7
			95	1	3
			55	1	3
			30	1	3
			20	1	3
			10	0	0
			40	0	0
			Total:	29	100

*Responses from Gecekondu Interview Participants
**Estimated by the Pharmacists

As a result of the one day boycott and petition to the Ministry of Health, the 10% profit cut problem was solved for the pharmacists. When I asked these pharmacists how they felt about the result, and the boycott in general, the answers I received are as follows:

–We wanted what we've deserved.

–I am glad about the boycott.

–The discounts should be stable. The association should pay on time.

–I don't want to talk about this topic.

–It brings pharmacies to bankruptcy, but this has changed and I am happy about that.

–We have our rights; we want our payments on time.

–We are happy now. Before I could go bankrupt.

–We are right. Now it is as it should be.

–We got what we deserved.

–The government should make the taxes lower instead of making our profits less.

–If we hadn't done it (boycotted) we couldn't get what we wanted.

–We had to close our stores for one day to get our rights, so I am happy about that.

In an effort to get the pharmacists to open up to the topics I asked about, I asked them to recount an interesting client or ailment they had treated in the past, and how they had dealt with the situation. Unfortunately, this question was met with more disdain than some of the other more straight forward questions (but to be fair, some of these questions were asked during business hours, and during intervals as clients entered and exited in quick succession). Some of the answers given for the "interesting complaint" question were as follows:

"I can't remember." (This was the most common answer)

"There weren't any." (This was the second most common answer)

"A patient came in yesterday who has a disease that stunts growth, and there wasn't much I could do for him, so I felt bad."

"Sometimes psycho people come in and ask for drugs."

"I've never had an interesting complaint."

I couldn't help but think that my anthropological distance was particularly unhelpful during these short interview schedules. I believe given the protest climate, and

media coverage of the time, guards were high. I'm sure that an insider's view of the situation would reveal a great deal more variation and opinion on the subjects touched upon. Of course for those who aren't covered by full medical insurance (i.e., many of the *gecekondu* people), the result of the pharmacy protest has little effect either way on their needs.

Misuse of the Health Care System

While Istanbul may seem geographically removed from some of the Civil War turmoil in the east, many residents in Ümraniye came from these regions, and would therefore be influenced by the attitudes pervasive in those regions – particularly with regard to medical care. Therefore, this conflict deserves further attention. The study of complex human emergencies is, according to Toole and Waldman (1990; 1993; 1997) a fairly young discipline, which only recently has achieved status as an area of global concern. Initially, the term was solely the designation for victims of war and other types of political strife–and was most notably the product of post-cold war politics, which resulted in the subjugation and forced migration of some groups to neighbouring countries. The result for the displaced population was often collective devaluation (psychologically and politically), and health problems of tragic proportions. Burckle (1999), describes some features common to all complex human emergencies, namely: there is a breakdown in management and the central governing authority, and one group is generally advantaged while another suffers. Most commonly, ethnicity is a deciding factor in choosing the "target," however, religion, race and other social, economic or

phenotypic criteria can lead to a political crisis and refugee situation. It is, in fact, the refugee situation that is most commonly at issue when one is discussing complex human emergencies; but in fact, displacement may occur internally or externally, and may be caused by human political agency, or natural (or technological) disaster (e.g., earthquake, flood, famine, etc). Whatever the reason, there are negative repercussions for the afflicted populations. Health related problems proliferate in what Waldman and Martone (1999) refer to as "the emergency room of life." For over a decade, groups such as the American Medical Association and the UNHCR (United Nations High Commission for Refugees) have taken up the international cause to expose these emergency situations, and the heinous crimes (note Rwanda and Kosovo) committed by the dominant (or controlling) force. While many within these refugee groups suffer disease, emotional and physical stress as a result of their compromised positions, it is the children who suffer the highest rate of mortality and morbidity. In particular infant mortality rate is highest among those ages 1-5 (see Toole and Waldman 1990, Waldman and Martone 1999, Burckle 1999, Yip et al. 1993). These authors cite two phases of the refugee crisis, namely 1) the emergency phase, which can be gauged (from a health status standpoint) as the crude mortality rate (CMR) exceeding that of the surrounding population, and more specifically as 1 death per 10,000 per day; and 2) the post-emergency phase, where mortality/morbidity rates more or less correspond to that of the encapsulating population or host country. For the first phase, and in particular the IMR, diarrhoeal disease (and associated dehydration) and pneumonia were cited most often as causes of death. For older children (to age 14), communicable diseases (in particular measles), as well as

respiratory infection, undernutrition and micronutrient deficiencies (most notably vitamin A in Turkey), caused morbidity and mortality. These observations were taken from the crises in Somalia, Iran, Kosovo, and other areas. In Turkey, while the refugee camps have given way to more stable living arrangements, the health profile of those involved–namely the Kurds–remains poor. Studies conducted by UNICEF and the Turkish Ministry of Health have shown the effects of civil war, poverty, social and geographical isolation have impacted the population. In 1997 multiple indicator cluster surveys were conducted on children in the southeast, the results of which point to under-nutrition and stunting. It has been nine years since the post-Gulf War (at which time many thousands fled over the Iraqi border to Turkey and Iran), and yet, much of the southeast (which is where these populations reside) suffers ill health. There are several contributing factors cited by the Turkish Medical Association (TMA) (1995). Focusing on a few of the larger towns–namely Diyarbakir and Batman–the TMA noted a high rate of communicable diseases, cholera, TB, and measles. They also note that there is poor sanitation in these areas, that public works are often sporadic or nonexistent, and, most significantly, that medical personnel are under-represented in this region, since many professionals refuse to practice in the area, after having become political/public targets of the PKK (the Kurdish Worker's Party, a political organization which sprang up in response to the Kurdish crisis). Therefore, the political/economic/health problem becomes a vicious cycle: in frustration, organizations such as the PKK attempt to voice their concerns in ways unacceptable to the Turkish government, and in fact target a group that could help improve or at least expose the health situation. Amnesty International has long held the

Turkish government responsible for human rights abuses. In particular, physician complicity in covering up governmentally sponsored torture of criminals (from common criminals to those whose crime is exercising cultural difference), is at issue. The American Medical Association has followed these accusations, and finds that the complicity is a product of governmental coercion (see Jones 1999). Of course Turkey wants to be accepted as part of the European Union, but with human rights abuses, breach of the Geneva Convention, and other human rights constitutions it doesn't stand a chance, and therefore must cover up its misdeeds. While the TMA is considered a responsible organization, comprised of nearly all the doctors in Turkey, the threat of incarceration (or worse) compromises their standard of medical ethics. The result is the aforementioned vicious circle of ill health, mistrust, and social-economic distance. A final note: In addition to the complex human emergency in the southeast, Turkey has had to deal with one of another sort in the west. After several earthquakes destroyed several towns just southeast of Istanbul, thousands of people became internally displaced (though the big earthquake was 3 years ago, tent cities are still in place where the town was decimated), and here we are bound to see health repercussions. Though both internally and externally the world rallied around these earthquake victims, the breakdown of social structure (entire families wiped out), and literally the living infrastructure has been destroyed, are sure to cause problems. This is something that bears closer scrutiny, and a watchful eye on those who are affected.

Attitudes toward doctor complicity in State torture

Examination of cross-cultural attitudes toward medical ethics is an area of great importance to bioethicists as well as medical anthropologists. Approaches to treatment, patients' rights, and practitioners' rights often shift with the cultural climate and unique circumstances governing regional activities. In Turkey, as well as in other parts of the Near and Middle East, civil unrest, natural disaster, and a shortage of medical personnel exacerbate health problems, and render problematic approaches to health care. While the doctors with whom I was in contact all demonstrated an exemplary standard for medical ethics, given their circumstances, this is not necessarily the case across the country. As mentioned throughout this dissertation, the individuals who migrated to Istanbul come from all over Turkey, and from all walks of life. Though my sample did not happen to include Kurds, they are part of the general migratory flow to Istanbul, and are situated in many of the other *gecekondu* areas in Istanbul as well as other urban areas of Turkey. Because of the civil unrest and poverty that exists in much of the nation, the Kurds are not isolated in their plight. Anyone who suffers the rages of poverty and civil war would be affected by adverse living conditions and poor health resulting from that situation. Therefore it is important to examine the unique situation facing medical personnel in this region, and most notably in southeastern Turkey, an area of civil unrest, due to poverty, lack of resources and the Kurdish crisis as many of these groups eventually migrate to urban centers such as Istanbul. Of particular interest is the idea of professional responsibility in the face of adverse conditions. Does the state have an obligation to provide political immunity to doctors working in areas where they are targeted for

political reasons? Do physicians have a responsibility to the sick that transcends their own sense of security? Furthermore, do doctors and other medical personnel have an "altruistic" responsibility to the poor and disenfranchised populations that have migrated to major cities in the region? This paper will explore the ethical aspects of the questions posed.

Human rights abuses

According to reports from JAMA (Journal of the American Medical Association), the Turkish Medical Association and Amnesty International, patient-physician confidentiality is on trial, and is used as a governmental policing device to keep suspects in check, and also to keep human rights abuses out of the international spotlight. As a result, there is a very real concern for personal safety. This situation is dire for medical personnel, who have sworn to maintain medical impartiality and promote ethical behaviour–but are bound by conflicting Turkish laws. Article 5 of the Universal Declaration of Human Rights states: "No one shall be subjected to torture, or to cruel, inhuman, or degrading treatment or punishment." This declaration stands juxtaposed Article 8 of the Anti-Terror Law, which calls for peaceful expression of opinions. The spirit of this law is zero tolerance for terrorist activities. As such, any activity–among a wide variety, such as speeches and even peaceful demonstrations–deemed to be of a separatist nature might constitute terrorist activity (Magnarella 1998). This "zero tolerance" has been translated into a physical response of abuse and torture. Summerfield (351: 1994) notes:

> In reports written after recent missions, both the UN Committee against Torture and the European Committee for the Prevention of Torture (ECPT) concur with Amnesty (International) that torture is institutionalized in Turkish police stations. In an interrogation room at Ankara police station, the ECPT delegation even discovered a stretcher type bed with straps, exactly as described by victims subjected to electric shocks, for which no credible explanation was proffered.

Iacopino et al (1996) in a JAMA article report that: "Turkish law officially prohibits torture, but it also promotes physician complicity with state sponsored torture." Subjects suspected of terrorist or anti-state activities may be incarcerated without due process, and are reputedly routinely tortured. Borderland areas of Turkey, which are areas known to harbour dissidents, have been targeted by the Turkish military. Turkish military personnel are said to be demoralized by the situation, and atrocities are exchanged, with the Kurds suffering the greatest and most visible casualties, while the military are proclaimed national heroes (military funerals become yet another forum for public denouncement of Kurdish rebels). The wounded, if they survive, are left behind and must be treated by local doctors. Medical forensic reports must be written, but unless the physician omits torture as probable cause of wounds, these reports could be confiscated and the physician jailed for negligence in denouncing a crime–the crime of course being terrorism, not state sponsored torture.

Of course the full extent to which these atrocities occur is not widely advertised in Turkey. A few miles from the border, one sees cities such as Diyarbakir–by no means a prosperous city, but it does have a deceptively cosmopolitan appearance. And across the country, in Istanbul, tourism continues, and these atrocities are just newspaper headlines. (This in spite of the fact that police and military brutality are seen here as well.)

Magnarella (1998) reported Lois Whitman's reaction to the findings of the 1992 Helsinki Watch, as heinous, and included observation of brutal treatment of adults (beatings, shock-torture, rapes) as well as children suspected of various political crimes. Medical personnel do possess some agency, and institutions such as the Human Rights Foundation of Turkey have been established. The Turkish government sees this as an aggressive act. "The Human Rights Foundation of Turkey, founded in 1989, operates four torture treatment centers in Turkey. It is no stranger to government attacks--a physician working as the foundation's representative in the Istanbul center will be brought to court" (Iacopino et al. 1996). Magnarella (1998: 289) reports that this foundation, during a 500-day investigation between 1991 and 1993, discovered that Turkish officials had tortured 804 people. Mucoz (1996) reported that the Human Rights Foundation has recently had to defend their support of international medical ethical standards against the Turkish government (1996:1396):

> In two previous trials, the court demanded that the Adana center turn over all of its files, including confidential records from survivors of torture whom it has treated, as well as the names of individuals who have collaborated with the center in its work. The defendants have refused the court's order, citing patient-physician confidentiality as one of their arguments. In their defense, Kose and Cinkilic have presented a dossier of statements from international medical professionals about how torture treatment centers operate as a document indicating that the files will not be provided to the court because to do so would breach patient-physician confidentiality....

So, while many physicians in Turkey are being criticized for compromising ethical standards, there are a great many who, at their own peril, fight to maintain the standard. Additionally, Dine and Ulusoy (139: 1998) when surveying a sample of Turkish nurses, found empathy among them toward civil war victims. When presented with the situation:

" A prisoner handcuffed to his hospital bed requests the nurse to inform his family of his admittance to the hospital. The nurse calls his family without the required permission of the authorities, " 76% if the respondents agreed that professional values (ethics) should be considered before legal issues. Here, respect for life was considered the more important issue. These same authors after administering a questionnaire to discern the most prevalent ethical problems among nurses found that "97% felt that nursing services should be managed by nurses rather than controlled by physicians, as is the case in Turkey." This response is perhaps indicative of the division between activist physicians, and those who are coerced into complicity with governmentally condoned torture centers. Speaking to this division, Iacopino et al. (1996:397) note the following:

> Ninety-six percent of the physicians who responded to the question (53/55) indicated that torture is a problem in Turkey. However, 45 physicians did not consider beatings alone to constitute torture, and 34 indicated that interrogation involving threats of harm or intimidation with no physical injury was not torture either. Fifty-six of the respondents considered severe physical and/or psychological injuries to constitute torture; 3 physicians did not. Regarding their views of the prevalence of torture in Turkey, 31 or 52 respondents to the question believed nearly everyone who is detained is tortured.

Additionally, there is a certain degree (albeit a small one) of autonomy/agency among prisoners. In a recent New York Times article (November 25, 2000), the Associated Press reported "almost 100 prisoners linked to outlawed leftist groups began a hunger strike last week...." Such acts of defiance are seeped into the public arena and serve to publicize the poor conditions under which these persons are forced to live, as well as the unfair circumstances, which led to their incarceration.

So it becomes clear that the ethical considerations change depending on the case and the perspective. For the Kurds, most of whom are not part of the PKK political group, these considerations are a matter of life and death; for the Turkish doctors working under the watchful eye of the government, complicity may prevent incarceration or worse, but at the expense of professional and humanitarian responsibility; for the Turkish government, concerns with national security cloud the situation. Their anti-terrorist laws–the attitude of zero tolerance-- are seen in our own country as well. The situation becomes further complicated by the rates of disease and malnutrition in the region–repercussions of political and social stresses. Of such conditions, Dedeoglu (1990: 391) says:

> The cause-effect relationship of health with poverty, unemployment and poor living conditions is well known. Research in Turkey has documented higher mortality and morbidity rates for rural and peri-urban areas. Official figures demonstrate that these populations have lower access to health services.

This is certainly an understatement when viewed in light of the aforementioned human rights abuses, and the statistics for health status described below. For Turkish medical personnel, it seems that while personal motivation may be aligned with one approach or another, professional responsibility is compromised all around. However, one may view the complicity of medical doctors with Turkish military in brutality toward detainees as an act of conscience based on the authoritarian ideal of an inseparable state, or in terms of a teleological stance–self-preservation, justification/rationalization/complicity to avoid personal danger. One may view medical personnel who delegitimize authoritarian practices with regard to torture, by working in organizations such as the Human Rights Foundation of Turkey, as a normative response–altruistic–to grave human rights abuses.

Also, this works on several levels, since the international standard for medical ethics is based on Hippocrates' tripartite medical doctrine–an orientation which focuses on the interrelationship among 1) the patient, a psychosomatic, vibrant entity; 2) the disease, and the natural rules by which it is governed; 3) the physician, "nature's helper" (Marketos 1999). This Western philosophy is underscored by a number of guiding principles, namely:

Nonmaleficence, which dictates the obligation of the physician to practice in such a way as to do no act that might cause any harm to the patient whatsoever.

Beneficence, which dictates that all actions of the physician must be of benefit to the patient (regardless of overall outcome).

Autonomy, which encompasses the freedom of the patient to make decisions for him- or herself and the physician's respect for such freedom.

Justice, which is the principle of treating all patients in a fair and equitable manner.

Veracity, which is the obligation of the physician to tell the truth.

Fidelity, which is the obligation of the physician to keep promises made to the patient.

Most of these ethical tenets are non-negotiable from a deontological perspective (the exception being beneficence, which takes on a more teleological/circumstantial role). Since medical doctors in Turkey are governed by Turkish law, which, as Magnarella (1998) notes is founded on a political base comprised of 1) Statism and Authoritarianism, 2) Military involvement in government, the economy and society, and 3) Ataturk's Principle of populism (1998:287), and are also bound by set of medical ethics, one sees conflict and compromise of values. However, having said that, I must also point to studies such as Turner's (1998), which examine bioethics in a culturally pluralistic world.

She notes that there are essentially two schools of thought with regard to cross-cultural consideration of medical ethics. The first school of thought asserts that there is a "core morality" that transcends political and cultural boundaries, and should be a universal basis for medical practice. Another group of scholars is guided by a more relativistic orientation, and "emphasizes local narratives, the heterogeneity of cultures, incommensurable moral worlds, and a diversity of moral tongues" (Turner 1998:127). Another consideration: the laws, which adhere to a Formalist stance, are actualized in the International Declaration of Human Rights and the Anti-Terror laws of Turkey. Both are intractable, and both are seen by their adherents to be non-negotiable. Yet on the playing field they have become mutually exclusive and co-existing orientations. The living law of Turkey, embodied by the military, views terrorism as a fluid and multi-faceted threat, and though it has attempted to conform to international standards and practices– in theory–it considers the terrorist situation to be a matter of national security. Therefore military counter-offensives launched in its name are viewed as legitimate and serving the greater good (that, of course, being Statism and authoritarianism).

While the ethical concerns are certainly of interest from an international-humanitarian perspective, in terms of anthropological inquiry–a field blessed (or cursed, depending on how you look at it) with a dualistic agenda (bound by metaphysical features such as educated intuition, reason and rationalism, and scientific methodology based on experimentation and empiricism), certainly a more holistic–in the truest sense of the word–approach to analysis is necessary. As mentioned above, there are serious health repercussions to the medical personnel crisis in Turkey. In medical anthropology in

particular there is a responsibility to the public and in particular the less advantaged parties involved, to expose social and political inequities. But to what extent is this appropriate for the anthropologist? Certainly health profiles and statistics may unite Turkish authorities and the world community to act. We have a unique perspective on marginal and displaced groups. For example, Van Der Stuyft speaks to the issue of inequity to shed light on patterns of morbidity among ethnic minorities (53:1989):

> With regard to ethnic minorities in general, sample surveys conducted in the U.S. indicate that ethnicity affects health care behaviour after control for social, economic and demographic factors. Associations have been found between the migrants' length of stay and their utilization of curative services and between length of residency and morbidity patterns. These findings suggest that acculturation or assimilation in the host society could be an important determinant of health status and illness behaviour.

By writing about the ethical pluralism and socio-economic stratification in Turkey, it is possible to expose conflicting political and social agendas in hopefully an informed manner. And by examining the two-sided exchange of casualties (both PKK sponsored and Governmentally sponsored acts of violence) one is able to look at the teleological processes underlying behavior. And yet there are no easy solutions to the problem. One sees, as a result, acts of violence and frustration committed by groups such as the PKK. As a result, there has been a decline in the number of medical personnel attending the region, and therefore an increase in preventable diseases. Another, repercussion has been a marked rise in popular Islam in politics in Turkey. Given democracy's promises of individual freedom and economic success, the rise of political Islamic fundamentalism might seem puzzling. However, when a country reaches a limit to its tolerance for

poverty and widespread neglect of the under classes, its citizens must look for a more culturally significant route. As Starkey (1992:33) observed:

> The power of populist Islam is directly derived from its ability to give expression to a wide range of discontents within various societies. It is this ability to appeal to and politicize the disenchanted that is most threatening to status quo forces. When the state and medical establishments fail to provide general security and well being, a more insulated and ethically self-serving cultural base must be tapped.

Conclusion

From the professional aspect, one can see that Turkey is host to a system that is complicated by social factors and a bureaucracy that often obstructs the resources available to both medical personnel and their patients. In terms of preventative care, and also treatment, this creates information gaps as well as a barrier to medical services. From the clinic observation excerpts one can see that quality patient-care is nearly eclipsed by administrative problems and also the ubiquitous pharmaceutical representatives, of which Ulus (2001) states:

> Their employers spend millions of dollars on their training and yet groom them with a car dealer mentality rather than the professionalism of health care. Most of them do not know how to approach the physicians and they are unnecessarily aggressive, if not arrogant. They compare their product A with the other company's product B—it was considered unethical in my day! – and they get irritated once the constructive criticism or feedback is provided by clinicians.

In addition to this, one sees that the skeleton staff at the public health clinic is overworked, underpaid, and subjected to poor working conditions. While making my observations at the clinic, Dr. Dilek provided me with a printout of patient visits for the year. This small clinic serviced 52,287 patients in 2001, with a minimal staff. With very little in the way of incentive, it is only a personal medical ethic that keeps health services

up and running. At the other end of the spectrum, the patients seeking services from these treatment centers have become conditioned to seek drug therapy at the whisper of an illness, largely because preventative care is lacking (or explanations thereof), and the attention they do receive is compressed (generally speaking) into a three minute examination and assessment. Therefore, they rely on prescriptions as the cure-all.

CHAPTER 10
DISCUSSION AND SUMMARY

Summary

Results of this study indicate that among the *gecekondu* women there is a heightened awareness about "correct" behavior with regard to illness and disease. However, while there was a general consensus among all sectors that 'the doctor knows best," the reality of the situation is that resources are not adequate to meet the needs of many of the lower SES inhabitants of the *gecekondu*, and stresses may be seen on both sides of the continuum: the doctors are underpaid and understaffed, the state hospital facilities are not on a par, technologically, with the private hospitals; because of inadequate care, there is some confusion on the parts of the population served by the state hospitals about the quality and attention (lack thereof) received. A crisis of confidence seems apparent in the attitudes people have fostered toward this health care system.

The results of this research also indicate a complex system of adaptation for the *gecekondu* women. While "traditional" values have become more or less eclipsed by regional Istanbul attitudes, undercurrents of the original value system are still seen in modes of dress (head scarves and conservative attire in general), community standards, religious orientation, and household division of power and labor. While many respondents gave the politically correct answers with regard to health care strategies, outward appearances pointed to a greater adherence to conservative, rural modes of

behavior. Additionally, a dual system of socialization was in operation with regard to internal community behavior and behavior toward outsiders (be they foreigners or individuals from another economic stratum or city).

Cross-Cultural Comparisons

While there are certain similarities among medical personnel (whether from popular, folk or professional sectors) in Turkey and in the United States, in general, the further away from the biomedical category one gets, the greater the social and structural difference between corresponding personnel. And even this is misleading, for while function may be similar, codes of ethics, social implications, and other factors may temper the behavior (and decisions) of medical personnel, as well as that of the recipients (patients).

In the United States, doctors are expected to adhere to the tenets of the Hippocratic Oath: to do good (beneficence), to respect the patient's autonomy, non-maleficence, and respect for the human body and the human spirit (that this is not always the case is another matter; this is the agreed upon ethical standard). However, cross-cultural attitudes toward patient autonomy differ. For example, while disclosure may be a part of the medical culture (with respect to patient autonomy) here in the States, where there are strong leanings toward individualism, in other countries (e.g., Italy, Turkey, Lebanon, and many supra- and sub-Saharan countries) the individual cannot be separated–or extracted–from the family, and as such, family is "in on" the decision making process. In Turkey, there is often a paternalistic attitude toward the patient, particularly if he/she is still living within the kin group. Therefore, one sees that while doctors (those grounded in Western medical science), may agree upon disease etiology and so forth (i.e., what Kleinman refers to as the statistical dimension of disease), the

clinical (personal/individual) approach to health care differs cross culturally.

In terms of other types of biomedical personnel, the situation is less clear. Onder (1998) reports complaints (by Black Sea Turkish patients) about Turkish nurses at the state run hospitals: they ignore patients, continue to sip tea and smoke while patients cry out in pain, and generally do not pay enough attention to their patients. This is not necessarily a culture specific value statement, but may be seen in virtually any society in which there is a shortage of medical personnel. Similar attitudes prevail in the United States: doctors and nurses are often construed as dispassionate and clinical, providing very little in the way of real comfort. In Turkey, as in many other Middle Eastern, European and African countries, medical care is a family event. Not only are family members (nuclear family and extended) part of the decision making process in health care, they are essentially responsible for the basic needs of the patient while he/she is in the hospital. In rural areas they provide the food, the linen, the news from home, and so forth for the ailing family member. This is largely because hospitals are sorely understaffed, underfunded and overcrowded (Onder 1998). For those without a family support system (e.g., those who, for one reason or another, have left their natal village, migrated, alienated kinsmen, lost a spouse, or children, etc.), the situation becomes critical. Onder (ibid) reports that such individuals must look to strangers and attempt to find a connection to illicit support based on "fictive relations." For example, an elderly man entering the hospital without a family support system may begin by questioning the security guard, asking him about his family, the town where he was born, and so on, to determine if a kind of extended obligation may be established. In fact, those who are established as having some kind of connection–however remote–are obliged to provide some comfort to the patient. This kind of open reciprocity may appear to be burdensome, but is rooted in the culturally defined reciprocal social support system.

In terms of other types of personnel, there are some similarities and differences between Turkey and the United States. The traditional midwife, for example is virtually non-existent in the U.S. While this system has, of late, included the midwife category and birthing centers as options at hospitals, this is a fairly recent development, the delay being largely due to a cultural penchant for biomedical health care. Though midwives are also RN's in the U.S., there has, in the past, been a certain stigma attached to the professional category. In Turkey, where the *koy ebesi* (traditional midwife) is still a viable category within living memory, medical professionalization has been a smoother transition. Particularly for the more rural areas, and for "traditional" Islamic women, the intimacy and social "correctness" of using a midwife supercede the need for a medical doctor. Of course this is not the case for all women, and as Onder (ibid) points out, many women use hospital births (particularly cesarean operations) as a kind of status symbol, which separates them from their "peasant" countrywomen.

Gender

In expressing attitudes toward gender, Turkey presents an unusual paradox in the Middle East: the civil codes and laws support equality between the sexes, but the de facto situation–gender *inequality*–is very much a reality. This can be understood as the product of a long tradition of social organization featuring patriarchal hegemony. Compared with some of the other nations in the Middle East (e.g., Saudi Arabia and Iran), attitudes toward women may be considered moderate: they are not required by law to cover their bodies, they have the right to vote, to own property, to divorce their husbands, to pursue an education, even to the highest political office in the nation. However, the law "in place" does not represent the social values adhered to by much of the population. Particularly, in conservative and rural areas (most notably in the interior and the

southeast, as well as mountainous regions), family law, public modesty and piety, and gender segregation are all in evidence. These social norms have been, historically, more intractable than civil law.

Abadan-Unat (1986) notes four distinct social (social-economic) categories that impact the lives of women. The settings are: 1) nomadic, 2) traditional/rural, 3) rural/changing, 4) migrant (*gecekondu*), and 5) urban (housewife). These lifestyles, the author notes, are important, because they illustrate distinct categories of social progression for women. As can be expected, the more traditional living arrangements and commensurate social organization are viewed as loci at one end of the "emancipation" continuum, while the urban locus is situated at the other end of this continuum. Somewhere in the middle is a transitional stage; best represented by migrant populations of women–frequently recent arrivals–many of who dwell within the *gecekondu* of the big cities.

In nomadic groups (an increasingly rare, and debatably extinct category) women play an important role both in terms of production and reproduction–the latter being the single most important contribution to her family and social group. While men are the sole negotiators for trade and "outside" business, in the domestic realm the woman is the most important element. It is her labor, her care and her skills that hold the family together. She is thus valued, but definitely not encouraged to look outside the family for any "personal" needs or pursuits. As long as she sticks to her role there is harmony (a simplified scenario, of course). Abadan-Unat (ibid) notes that the work aspect is significant, for it is considered an integral contribution in tribal society. This is contrasted with the situation for women in the traditional rural village.

There is also a division of labor, with male and female tasks clearly delineated. Reproduction is the most virtuous aspect of matrimony; but a woman's work is devalued,

despite the often-unequal amount she is expected to perform (in addition to child care, care of in-laws, cooking, cleaning, and maintenance of livestock, she is often responsible for the bulk of agricultural endeavors as well). As is evidenced in recent news coverage of young women in rural Turkey, this can be an overwhelming amount of responsibility. The New York Times (November 3, 2000) recently reported a rash of suicides (mostly young married women) that, after struggling with such workloads, considered suicide their only recourse. While a newspaper article may be sensational, it does indicate a change in the tide for women who are not equipped to handle so much stress, and cannot turn to family for support. Their world is isolated. Unless a woman has a sympathetic spouse, willing to move, this is a fact of life. In fact, many couples do migrate to the cities to avoid the vicious social cycle. The sprawling *gecekondu* of the major cities are the primary destinations for many rural inhabitants who desire a different lifestyle. Some leave to avoid vendetta, some in response to what Karpat (1975) calls the "push" and "pull" factors of economic stress. Some migrate to get away from their filial duties, and for the woman the "gelin" (daughter-in-law) duties that are a part of social and familial protocol. However, Tekeli (1995) notes that even in the *gecekondu*, only about 30% of the women find employment (this in contrast to the 93% of men who are able to find work). When they do find work it is usually as domestic workers, or self-employed artisans. Of employment and household relations for the rural to urban migrant Kandiyoti (1977) says: "The chances of having access to education and of entering a wider variety of gainful occupations are obviously enhanced in large urban centers." Ostensibly, a conflict of ideologies about female roles must be evaluated, and can make the change a difficult one for the women. But this lifestyle, though hard, does yield some positive things for a woman: living with only the nuclear family, eventually building the means to purchase, by deed, what was initially a squatter dwelling, and to improve its

condition and worth. Women may find better health care (though this is still an underserviced area–the *gecekondu*–medical ambulatory care is available).

This brings us to the topic of health care among women, in the context of the Middle East in general. Much of the topic of reproduction has been covered. In Turkey, women are legally "free agents". They may use birth control (in fact this is available without prescription at pharmacies), abortion is legal (until the 10th week of pregnancy), and given the medically pluralistic environment, she has a number of options when seeking a medical practitioner. Licensed midwives are available, as are traditional midwives, religious healers, doctors, herbalists, pharmacists, doctors, nurses, bone setters–are all choices, and depending on her financial status, these options may all be available to her. While conditions are not yet ideal for women in Turkey, small steps are being made toward greater equality between the sexes. The legal apparatus is in place, but traditional attitudes persist, even in urban areas, and require a pluralistic strategy on the part of these women, who must adapt to meet the needs of many.

Historically a woman's role was clearly defined in terms of family and reproduction, the women's movement in Turkey is growing stronger. National agencies such as the Committee for Policies for Women, the Center for Research of Women's Problems, and the Department for Women in Rural Development are only a few examples of organized bodies looking to redefine women's roles in Turkey.

Economy

A final note on the economic status of *gecekondu* residents should be made. In April 2001, the Turkish Lira dropped from around 600,000 TL to the U.S. dollar to 1,250,000 TL to the dollar. In September 2002, the lira plummeted even further, to around 1,600,000TL to the US dollar. Such depreciation of the currency in the absence

of matching pay increases compounds poverty and livelihood in Istanbul. Those who live in the notoriously poor regions of the *gecekondu* will no doubt suffer even greater hardship in the face of inflation and loss of income. Since many aspects of real estate and commerce are regulated at a fixed rate, adjustments to inflation are limited, and one ends up paying nearly 100% over the established rate for things like rent and basic utilities. To those with little or nothing to begin with, this financial crisis can be devastating and demoralizing. During my short interview schedules I asked respondents about the economic crisis and how it affected them. Overwhelmingly the response was: "We had very little before, and now we have even less." In terms of the subject of this dissertation—health care and strategy—this is bound to have serious repercussions for the next generation as well, particularly in terms of nutritional intake and chronic diseases.

Repercussions

In addition to the issues mentioned above, one must consider the repercussions of poverty, unemployment and health status that emerge in not just the rural southeast, but also in urban areas throughout the country. Agacfidan et al. (1993:236) note: "due to recent changes in social migration and economic difficulties in Eastern Europe, the population of unregistered prostitutes in Istanbul, Turkey has increased." Though few STD surveys have been conducted in Turkey, it is fair to assume that widespread "freelance" population of sex industry workers will lead to an increase in STD's [regulated/registered prostitutes undergo routine medical STD screening]. As a result of the increase in prostitution, repercussions are likely to be felt among all SES groups. While the issue of STD's may not be a critical issue at present, the marginalization of health care recipients is. Van der Stuyft et al. (1989), in studying patterns of behavior,

with regard to utilization of public health care, noted that among migrants acculturation was a primary factor with regard to health care practices. The authors state:

> This study indicates that length of stay is only marginally associated with health care behavior, and that longer periods of residence do not directly lead to conformity with health care attitudes and standards of the host society. Acculturation, on the other hand, seems to be a strong determinant of the migrants' utilization pattern of primary care, but it does not straightforwardly decrease the utilization differentials with the native population, and traditional health care attitudes can partially persist in migrants with high degrees of cultural identity change (Van der Stuyft et al. 1989:59).

It seems that the above quote may, in fact, refer more specifically to culture change than to acculturation, which one would expect to create a mutual feedback with the dominant and encapsulating social system. Therefore, alienation of lower SES groups, immigrants, and other disenfranchised peoples can and will work against society as a whole.

Additionally, poor nutritional status associated with diseases is prevalent in many parts of Turkey (as mentioned, the result of immigration, poverty and civil war, social alienation); therefore health care is not a black and white issue. Because of poverty and extenuating circumstances, those affected by disease and adverse conditions are forced to resort to a combination of folk and biomedical resources.

The TMA (1995) reports an increase in/return to midwifery for pregnant women due to expensive and inconvenient public health care. Additionally, though health care personnel are scarce (or too expensive) in many areas, pharmacies, though regulated, offer many over the counter (OTC) drugs, which are accessible to these people. Stirling (1993:165) remarks: "It is very common to begin treatment [of an illness] with 'pharmacy medicine'. Often an assistant with no formal education plays an important

role." The rural population is not isolated, and consequently, a kind of medical syncretization has occurred, though regional variation is seen (Stirling notes that urban inhabitants interpreted OTC drug directions more accurately than those of the rural eastern provinces) (also see du Toit 1998 for assessment of reinterpretation of uses of OTC drugs among African groups).

Eskin (1989), in trying to discern opinions about the causes of mental illness, and preference for medical specialists, found that the traditional healer (*hoca*) ranked lowest in efficacy compared to psychiatrists (first) and mental hospitals (second). He also notes, "consulting the hodja [sic] for a 'muska' (amulet) is a common practice among the rural population in Turkey but this practice perhaps reflects the unavailability of modern psychiatric services rather than a positive choice" (1989:327). Considering the great number of nervous disorders seen in the Ümraniye area (as evidenced by physician and respondent testimonies, I would venture to say that while treatment options and order of resort are interesting areas of study, the social and economic reasons underlying an increase in the use of anti-depressants and other psychotropic drugs bears further scrutiny.

In a related area, Stirling (1993), found that private doctors were the first choice (hospitals were regarded with suspicion, due to depersonalization factors, and overcrowded waiting rooms) for seriously ailing individuals, but when medication was prescribed, many respondents "reinterpreted" the advice with the aid of a local pharmacist. These findings corroborate doctor testimony in Ümraniye that drugs such as antibiotics are grossly overused for any number of ailments. Given the general lack of

communication between medical personnel and their patients (at this level of health care) it stands to reason that for many medical and nutritional conditions for which an immediate, biomedical solution cannot be found, the afflicted must fall back on culturally defined, socially significant strategies, or supplement such strategies with innovative, and resourceful methods (such as medicinal plants, folk specialists, recombination/application of over the counter drugs). However, despite such resourcefulness, and despite a growing body of literature devoted to exposure, nutrition and disease continue to be a problem among lower socio-economic groups. Ostensibly this will continue unless political and governmental policies are altered to include a more community based approach to health care reform (Tatar 1996).

Conclusion

The driving hypothesis (Hypothesis 1, see chapter 1) behind the research undertaken in the Umraniye gecekondu was, in my mind, that when a sector of the population suffers from social or economic inequities in relation to society as a whole, health status will suffer as a result, and those individuals without the means to pay for advanced medical care will fall back on traditionally meaningful methods of remedy. Hypothesis 2 proved to be closer to the truth, at least in terms of public behavior:

Hypothesis 2: When rural migrants are faced with health stresses in the new urban environment, social pressures from the urban matrix will cause a re-evaluation of traditional treatment of and attitudes toward illness, and force those individuals to adapt the encapsulating health care system.

One of the premises implicit in the research design, was that nutritional intake (quality thereof) would be an indicator of health status. My brief nutritional assessment in Umraniye showed that while caloric intake appeared to be adequate (judging from average BMI), the quality and proportions (particularly proteins) were insufficient, and would be considered substandard in terms of health maintenance. However, given that the respondents did not suffer from starvation, one may assume that though they lived below the poverty line, basic needs were being met.

Another question I examined was the interrelationship among health care sectors (professional/biomedical and folk) to assess the extent to which services from each are used by the core sample from the *gecekondu.* Results of this study show that *gecekondu* women were well aware of the various health resources available to them. In general terms, strategy for dealing with illness included everything from herbal therapy, most commonly seen in use of teas (e.g., peppermint and linden bark), to use of primary health care at the public facilities. A few respondents also reported using the services of a spiritual *hoca* to combat a medical complaint. As I made my rounds one day, I came across a young woman. She agreed to be interviewed for my research, and answered the questions thoughtfully. She told me she had no knowledge of herbal medicine, and had not been exposed to it a great deal. One of my more open-ended questions was "Is there anyone other than a doctor that can cure an illness?" Her reply was "No." However, when I asked her questions about childbirth and beliefs, it came to light that she was not able to have children. She had been for fertility tests, taken vitamins, and had been to a stomach puller—all to no avail. Finally, she sought the services of a local *hoca*, who

read a prayer over her to help with conception. Though the spiritual/folk avenue was the last she pursued, it was nonetheless within her scope of possibilities in terms of medical order of resort.

When one considers that the Umraniye women had experienced everything from anemia to ingrown hair—and everything in between—it is reasonable to assume that they possess the agency to deal with their problems one way or another. If the doctor can't solve the problem, perhaps it will go away, or perhaps an over-the-counter drug might solve the problem. Failing that, there are other choices, and the women with whom I spoke were well aware of these options.

The purpose of the project was to identify the mechanisms for transfer of medical knowledge, with special consideration for epistemological and ethno-medical dimensions, which are informed by beliefs, social organization, religion, politics, and the relative isolation (socially, economically, geographically, etc.) of a particular community. While I would have been delighted to learn of ancient healing practices secretly performed by my core sample, the real question had to do with strategy and survival in relation to illness. My respondents showed me that they are aware of the benefits of professional medical care—and also aware of its limitations. They are a literate group, and have access to media, pharmacies, and others women who may have experience with a certain health care sector. While it is not possible to make a sweeping generalization about "What the *gecekondu* women do when they have an illness," it is possible to outline some of the difficulties they face on a day-to-day basis, and how they handle those stresses.

GLOSSARY

Albmasi – "raid of red": a type of genie that afflicts women only.

Alkarisi – a kind of witch characterized as having long hair and nails, big breasts, and wearing red.

Ataturk – the founder of the Turkish Republic and first president of Turkey

Baslik – bride price; also headdress.

Cin – a minor demon or genie.

Dolmus – a form of public transport: a shared taxi (mini van)

Ebe – midwife (usually a nurse).

Gecekondu – Squatter settlement areas in Turkey (literally "built overnight")

Gelin – "one who comes": term used for new daughter-in-laws

Hastane- hospital

Hoca – a teacher, and specifically in the present paper, a religious healer.

Ilgi – "attention" or "care" in relation to health care services on a personal level.

Imam – prayer leader; one who is well versed in the Koran.

Kazim Karabekir Mahallesi – the quarter of Umraniye where my interviews were focused.

Kirklama – a ritual bath

Koy ebesi – village midwife.

Kurson dokme – to pour molten tin into cold water

Lohusa (alt. Logusa) – :woman recovering from childbirth"; 40 day period of caution after a woman gives birth.

Mahallessi- neighborhood, quarter

Melek – an angel

Muska – a written charm or amulet

Nazar – the evil eye

Peri – a fairy

Refah – "Comfort" OR "Prosperity"; also a political party in Turkey with an Islamist agenda.

Saglik Ocagi – village health clinic

Su dokme – to pour water

Tutsuleme – to inhale smoke.

Tuz patlama – to burn salt

Umraniye – A district of Istanbul located on the Asian side, where the present research was conducted.

APPENDIX A
UMRANIYE INTERVIEW QUESTIONS

ID # _____ Date: _____ Visit: 1 2 3 4 ____ Area: _____

Arrival Time: _____ Departure Time: _____

Physical Description of location:

Part I: Biographical Information

Where were you born? _____

How long have you lived in Istanbul? _____

Do you like living here? _____

If from elsewhere, what are some of the things you miss from back home?

What are some things that are better in Istanbul?

Where are/were your parents from? _____

Do you have any relatives in Istanbul? Yes No N/A

If yes, do they live in Umraniye? Yes No

If no, where do they live? _____

Are you married? Yes No

Where was your husband/wife born? _____

Where does most of his/her family live? _____

Are any of your husband's/wife's relatives living in Istanbul? Yes No

If yes, which relatives? _____

Do you have any children? Yes No

If yes, how many children do you have? _____

What are their ages (and boy or girl)?

_____

_____

_____

Do they attend school?

Did you attend school?

What was the highest grade completed?

What are your views on education? Is it:

a) extremely important
b) somewhat important
c) not very important
d) important for boys
e) important for girls
f) important for boys and girls

g) unsure

Do you speak any languages other than Turkish? Yes No

If yes, what are they? _____

Part II: Economics

Do you work outside the home? Yes No

If yes, what kind of work is it?

_____

_____

Does your husband work? Yes No

If so, what kind of job is it?

_____

Is there any other income (e.g., from other relatives)? Yes No

Do any relatives work in other countries (e.g., Germany)? Yes No

Do they send remittances (or gifts) back home? Yes No

Which of these animals (and how many of each) do you own:

1. Sheep
2. Cow
3. Chicken
4. Goat
5. Other _____
6. I do not keep any animals

Do you have a garden? Yes No

If so, what kinds of things do you grow?

Are these items for home use or to sell at market?

Do you grow any other types of plants (herbs, flowers, etc)?

How much would you say your weekly income is?

Has the recent economic crisis and inflation affected you?

If so, how?

Part III: Nutritional Information

In general, how many times a week do you eat meat?

1-2

2-3

3-4

4-5

5 or more

In general, how many days a week do you eat any of the following:

Bread	0	1	2	3	4	5	6	7
Yogurt	0	1	2	3	4	5	6	7
Milk	0	1	2	3	4	5	6	7

Ayran	0	1	2	3	4	5	6	7
Cheese	0	1	2	3	4	5	6	7
Eggs	0	1	2	3	4	5	6	7
Fruit	0	1	2	3	4	5	6	7
Tomato	0	1	2	3	4	5	6	7
Corn	0	1	2	3	4	5	6	7
Leafy Veg	0	1	2	3	4	5	6	7
Other Vegetable (cucumber, legumes, carrot, etc)	0	1	2	3	4	5	6	7
Beans	0	1	2	3	4	5	6	7
Rice	0	1	2	3	4	5	6	7
Bulgur	0	1	2	3	4	5	6	7
Potato	0	1	2	3	4	5	6	7
Sweets	0	1	2	3	4	5	6	7
Tea	0	1	2	3	4	5	6	7
Coffee	0	1	2	3	4	5	6	7
Cola	0	1	2	3	4	5	6	7

Part IV: Medical Information

Do you have medical insurance? Yes No

If yes, what kind is it? _____

Have you ever had:

Hypertension Yes No
Diabetes Yes No

Headaches	Yes	No
Arthritis	Yes	No
Liver problems	Yes	No
Kidney problems	Yes	No
Eye Problems	Yes	No
Thyroid Problems	Yes	No
High Cholesterol	Yes	No
Heart Problems	Yes	No
Anemia	Yes	No

If you answered yes to any of the items above, who made the diagnosis?

How was the problem treated?

Was the treatment effective?

If no, please explain why.

Have you ever been diagnosed with any other serious illness? Yes No

If yes, what (and when) was it?

What was the treatment?

Was the treatment effective? Yes No

If no, please explain why:

Have you ever had to be admitted to a hospital for any reason?

If yes, how many days did you stay there?

In general, did you find the nurses attentive and sympathetic?

In general, did you find the doctor to be attentive and sympathetic?
How would you rate your hospital visit overall:

a) very good, I received excellent care and attention
b) horrible, I hope I never have to go back
c) my treatment was effective but I found the staff inattentive
d) the staff were helpful, but the medical treatment was not effective
e) other _____

In terms of cleanliness, did you find the hospital:

a) very clean
b) reasonably clean
c) somewhat unclean
d) dirty
e) other _____

How tall are you? _____

How old are you? _____

What is your approximate weight? _____

Do you smoke?

If yes, approximately how many cigarettes a day?

How often do you drink alcoholic beverages:

a) once or twice a year
b) once a month
c) once a week
d) several times a week
e) every day
f) I don't drink

In your house, who would you say takes care of most of the health care needs?

_____

Are there any special precautions you take to prevent the onset of illness?

How would you treat the following complaints:

cold or flu:

A fever (for a baby or child):

Diarrhea (baby or child)

Diarrhea (adult)

Fever in an adult:

Upset stomach:

Headache:

Nausea:

Sprained ankle:

Broken wrist:

Rash:

Cough:

Congestion:

Constipation:

Nervousness:

Insomnia:

Eye infection:

Ear ache:

Menstrual cramps:

Labor pains:

Diarrhea:

Gas:
Heartburn:

Infertility:

Aside from the doctor, is there anyone else who can give medical advice?

Do you ever ask the pharmacist for medical advice?

Have you ever been helped by a hoca?

What is your experience with hoca?

How do you decide if an illness is serious enough that you must see a medical doctor?

Are there any home remedies that you find effective?

What are they? What are they used for?

Did you ever receive any medical recipes from your mother or grandmother (or from friends)?

What are some examples?

Did you find that they helped? Yes No

Do you know of any (or any other) plants or teas that can be helpful in treating an illness?

Are there any particular foods that are helpful to eat to either prevent illness, or to help someone when they are ill?

What are some examples?

What do you think the most common type of illness is for people (in your own family, or among your friends and neighbors)?

How about for children?

Have your children been vaccinated against measles / mumps/ tetanus? Yes No

Do you use any over-the-counter medications? Yes No

Which (if any) of these products do you keep in your home:

a. aspirin
b. cough medicine
c. band-aids
d. anti-bacterial ointment
e. throat lozenges
f. antiseptic
g. eye drops
h. vitamins
i. anti-diarrheal
j. decongestant
k. anti-allergy (antihistamine)
l. thermometer

If respondent has children: Were your children delivered at the hospital or at home:

Were there any special precautions you took (or one should take in general) before the baby is born to ensure good health?

How about after the baby is born?

How long did you breast feed?

What are the advantages to breast feeding, for the mother and the baby?
a) immunological
b) nutritional
c) contraceptive
d) economical
e) no response

Did you experience any complications during the births of your children?

Did you use a village midwife or a government (RN) midwife?

What was your experience with her? (E.g., positive, negative, neutral?)

What, in your opinion, is the ideal number of children to have?

Part V: Religion/Beliefs

How important is politics to you?

a) extremely important
b) somewhat important
c) I am not interested in politics
d) I am not sure

If you answered a) or b), with which party do you most identify?

How important is religion to you?

a) extremely important
b) somewhat important
c) I am neutral on the subject

d) I am not a religious person

If you answered a) or b), do you believe there is a spiritual or supernatural presence in life?

What are some examples?

In general, do these things have any effect on one's health?

If yes, what are some examples?

Do you think there is a way to "combat" these forces?

How important is prayer?

Do you own your home?

If so, how much was it to purchase/build (approx).

If you rent, how much is monthly rent?

Do you own:

television
cd player
telephone
cell phone
washing machine
radio
car

What is the source of water for your home?

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT FOR INVESTIGATION OF FOLK HEALING PRACTICES IN TURKEY
My name is Mary Allen, and I am an anthropology student from the University of Florida in the USA. I am very interested in learning more about how people handle illness–and how their knowledge about healing certain types of illness is used in everyday life. The purpose of this consent form is to make you aware of the type of information I am looking for, why I am interested in it, and how I plan to use the information you give to me. I am particularly interested in how people deal with illness in this area of the city, the gecekondu. I will write about the things I learn, and present them to my university, as part of my training as an anthropologist. These findings will be published and kept in the university library for anyone who wishes to learn more about this subject.

As I learn about the ways in which people handle the stress of illness, I will take notes, photos, and also use an audio tape recorder. The recorder is to help me quote you accurately, and photos may be used to show how you live, or how you care for the ill, or how you prepare a certain medicine. I will spend a year living in your community and speaking with different people in this community. I also want you to know that the questions I may ask, since they have to do with illness, are likely going to be personal. The *risks* of participation are disclosure of medical conditions, disclosure of medical practices, and disclosure of private events of your life; however, any information you give me is guaranteed to be confidential to the extent provided by law. I will use an alternate name when describing what you have to say so others do not know who you are (unless you specifically want me to use your real name). The perceived *benefit* of your participation is that the academic and medical community will be informed of–and therefore better understand–the health stresses and local solutions that impact your life. If at any time you feel uncomfortable answering a question, or having a photo taken, or having me tape record a conversation, I will honor your wishes and stop what I am doing. Also, if at any time you decide you no longer wish to participate in my study, you are free to stop participating. My goal is to learn about illness in the gecekondu, but only from those who wish to share their opinions. Below, I have a few statements for you to sign. Your signature does not obligate you in any way, but does show that you understand what I am trying to do. The signatures also show that you do not mind participating in this study; that you do not mind having conversations recorded, and that you do not mind having your photo taken. These statements are not legally binding, but serve as a contract between us alone.

I do _____ do not _____ wish to participate in this study, and to answer questions about health and illness, and my opinions for Mary Allen's project.

I do _____ do not_____ give Mary Allen permission to take photos of me, my home, or any activities in which I am engaged.

I do _____ do not _____ give Mary Allen permission to record our conversation(s) with an audio tape player.

conversation(s) with an audio tape player.

I have read or had read to me the information described above. I have received a copy of this form, and I willingly agree to participate in the interview. I have not been coerced in any way.

Participant:

_____

Date: _____

Witness: _____

Project Director: _____

Project Investigator: Mary Allen, 7517-C Pitch Pine Circle. Tampa, Florida, USA. Affiliated with the Department of Anthropology, University of Florida, Gainesville, Florida 32611. Tel: 813/989-1069; email: mballen@ufl.edu.

Project Supervisor: Brian M. du Toit or Leslie Lieberman, Department of Anthropology, University of Florida, Gainesville, Florida 32611. Tel: 353/392-2253.

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I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

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